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**THE
MARYLAND
PHARMACIST**

Official Journal of
The Maryland
Pharmaceutical
Association

JANUARY, 1981
VOL. 57
NO. 1



The Case for the “Doctor of Pharmacy” Title

A Century of American Pharmacy

Health Maintenance Organizations in Maryland

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
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JANUARY, 1981

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It has been said, "No man's life, liberty or property are safe while the General Assembly is in session." While this may be somewhat of an exaggeration, it is true that constant vigilance is necessary during the next few months. The most important factor in lobbying the legislature is "credibility". The men and women who represent us in the legislative process quite often are not familiar with the many intricate issues in health care. They must rely upon others for their source of information upon which to base critical decisions. We must continue to be a good source for accurate and reliable information to the legislators on all issues; those we support or oppose. The fine work of the Legislative Committee and its Chairman, Milton Sappe, and Pharmacy's lobbyist, David Banta, does provide our representatives with a clear source for that credible information.

Lobbying is, of course, an inexact science. But it is one specific area where pharmacists can, at least, influence their own destinies. You can help. Let Dave or Milton know of any personal contacts you have with state legislators. In the past these contacts have proved very valuable to the overall effort. Participate in the policy making process that the Association utilizes through the House of Delegates mechanism to arrive at legislative positions on specific issues.

In the near future, the Association will be arriving at policy decisions that will affect *all* pharmacists. Encourage non-members to get involved and strongly voice their opinions on issues. If they have not participated in the system, then they have little right to complain when the Association takes a stand with which they disagree. Influencing our own destinies and that of our profession must be a continuing concern for all of us. The legislative process provides us all with an excellent opportunity to contribute.

Samuel Lickter

The Case for a "Doctor of Pharmacy" Title

To date, five state associations and one school of Pharmacy have adopted the designation P.D., with the title "Doctor of Pharmacy", to replace the standard designation, R.Ph. The position paper presented here was prepared by the Indiana Pharmaceutical Association to explain why these organizations changed their designation for pharmacists.

At its Convention in June, the Maryland Pharmaceutical Association adopted a resolution calling for a study of the issue of pharmacist professional designation. President Lichter has begun the formation of that Committee. It will soon begin its work and eventually make a recommendation to the Association's House of Delegates.

David Clark, Executive Director of the Indiana Pharmaceutical Association and primary author of this paper, is scheduled to address the Spring Regional Meeting of the Association on March 12, 1981. Indications are that it should be a well-attended meeting. Watch for further details and plan now to participate and express your opinion.

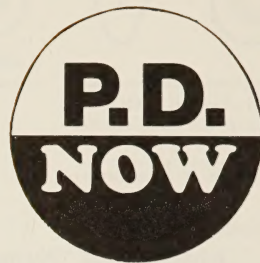
Now is the time to adopt the uniform designation of P.D. for all pharmacists. The P.D. designation carries with it the title, Doctor of Pharmacy. Now is the time to correct some of the mistakes that have been made in the past.

Pharmacists must join together now and remedy the mistakes that were made in 1918, 1932, 1948, 1950, 1960, and are still being made today. These "mistakes" relate to the fact that we have not awarded a "Doctor of Pharmacy" degree traditionally to the people who graduate from pharmacy school. At each of these times we have had the opportunity to grant a "Doctor of Pharmacy," and have not done it. Pharmacists deserve the recognition of the title Doctor of Pharmacy, but the times have passed us by — until now.

16 SCHOOLS ANNOUNCE DROPPING B.S. PROGRAMS!

As you know the Pharm.D. degree, which carries with it a Doctor of Pharmacy title, is now awarded for the completion of six years of pharmacy school. This degree has been adopted by many schools and now pharmacy schools are abandoning their five year B.S. programs and granting *only* the six year Pharm.D. degrees.

Schools have begun to grant Pharm.D. degrees to *some* pharmacists, and we have been satisfied to let the educators tell us they are a "new breed" and "special" kind of clinical pharmacist. How many other professions have allowed the educators to upgrade the educational standards and *not* "grandfather" the existing practitioners? You already know the answer — none of them! They *all* have grandfathered the new degrees or titles to their present practitioners. We want to make certain that the four and five year B.S. graduates are not left with an *obsolete degree and title*.



TRANSITION PERIOD?

We believe that it is unthinkable that our schools are training two levels of pharmacists, who will have different degrees, different titles and both practice under exactly the same license with exactly the same powers and limitations. How can both be correct? It's a transition period they may say, but let's not be *victims* of the transition.

JOB DISCRIMINATION?

Many schools are eliminating the B.S. program and granting *only* the Pharm.D. As this trend continues, and it will, there will be more and more Pharm.D.'s and fewer and fewer B.S. graduates — *and* more and more pharmacy school trained two year *pharmacy technicians*. How will all of this affect you and your employability in 10 or 15 years? It will have a profound effect if we don't do something *NOW*.

When most, or all new pharmacy graduates receive a Doctor of Pharmacy degree (Pharm.D) will you, the pharmacist with a B.S. degree, be satisfied to try and compete for jobs with younger pharmacists who are *all called* "Doctor?" IT WILL AFFECT JOBS!

THIRD PARTY RESPONSE

Will the title "Doctor of Pharmacy" help our ability to be paid by the public for the services we now give away, such as consultation? Will the "Doctor" title give us a better bargaining position with 3rd Party payors? The obvious answer is "yes" because the *lack* of a "Doctor" title will hinder us when others *are* entering the profession with a "Doctor" title.

Anyone who says there is "nothing in a title" doesn't understand human nature — *or already has a title*.

If we did not grandfather the Doctor title to all pharmacists we would be creating a *second class* of pharmacists who will be discriminated against by the difference in titles. We can't let that happen.

The schools have said that they would try and make it easier for us to come back to school and earn a Pharm.D. To ask pharmacists to return to school to get a Pharm.D. would be economically unfeasible and create family and personal hardships. Other professions did not require the practitioners to return to school.

PHARMACY EDUCATION-OUT OF STEP . . . BUT — IT'S NOT TOO LATE!

Unfortunately, pharmacy education has been out of step with the other professions for years by not granting a Doctors degree to all practitioners. We have been one step behind in the professional evolution of pharmacy education and *it is you, the practicing pharmacists, who have paid the price*. The decision was made to require a four year B.S. degree for all pharmacists to begin in 1932 when other professional schools were granting Doctorates. We missed the boat. In 1948 the Elliott Report recommended two years of college and then four years of pharmacy college, leading to a (Phar.D.) Doctor of Pharmacy degree that would reward the pharmacist with the recognition earned and deserved by other health care professionals. What did our leaders do? They *compromised* and went to a five year program and still offered only a B.S. degree, not much of a bargain as many of us know first hand. One school in California started granting a Pharm.D. (Doctor of Pharmacy degree) in 1950 as the only degree they offered in pharmacy school. This trend was later followed by many other schools.

Now we have: Some schools offering a Pharm.D. only; some schools offering both B.S. and Pharm.D.; some schools offering B.S. programs only.

Where did this lead us? We now have pharmacy schools offering two different practice level degrees, with two different titles but — remarkably — *all* practicing under exactly the same license. If this sounds odd to you, you're not alone! You may not think it's a big problem now, but why wait until it is a major problem to *do something about it*? Why should we be willing to settle for less than all the other professions? We need to adopt a uniform designation that tells everyone we are a pharmacist and carries with it at least the *title* Doctor of Pharmacy.

WHY THE P.D.?

We now need to determine what designation would be appropriate, dignified, have historical significance and be readily identifiable. A total examination of our predicament calls for looking into the future for what will likely happen, looking to the present for what is going on now, looking into our professional history to see what our great leaders of the past have offered to our predecessors. Because the Philadelphia College of Pharmaceutical Sciences (PCP) was the first pharmacy school in the United States (founded — 1822) we have used that school as the major source of historical information, since this school is a historical barometer of our profession's development. In 1893, a very farsighted and influential pharmacy educator and practitioner, became Dean of the Philadelphia College of Pharmacy (PCP). It was his very strong conviction that a Doctor of Pharmacy title was essential for pharmacy practitioners. As a result of his influence, PCP began issuing a diploma for "Doctor of Pharmacy" which carried the designation P.D. The P.D. was granted from 1895 until 1917. The spearhead of this concept of the necessity of a "Doctors" title was none other than *Joseph P. Remington*, one of pharmacy's great visionaries and leaders, who wrote Remington's Practice of Pharmacy, and in whose name the Remington Medal is awarded for outstanding pharmacy achievement.

What better historical precedent could be found for deciding on the uniform designation for all pharmacists than the actions of Joseph P. Remington? The mistake that was made in 1918, after Remington's death, was the reversion to a pharmacy curriculum that granted the Ph.G. (Pharmacy Graduate) for a two year program, and abandoned the Doctor of Pharmacy program. *All Pharmacists have been paying for that mistake ever since.*

DEFINITION OF TERMS

A "designation" is — the *initials* used to express the identity of a person or professional person in our case. Examples: M.D. for physician; O.D. for Optometrist; J.D. for attorney; P.D. for pharmacist. The P.D. designation will be used for all pharmacists, regardless of their level of education just as has been done with all other professions.

Advanced professional degrees such as Pharm.D. and advanced research degrees such as M.S. and Ph.D. will be used after the P.D. designation. Examples are as follows:

James R. Smith, P.D.

James R. Smith, P.D., M.S.

James R. Smith, P.D., Ph.D.

James R. Smith, P.D., Pharm.D.

The Pharm.D. degree should not be confused with advanced *research degrees* such as an M.S. or Ph.D. The use of the P.D. should in no way detract from the prestige of the Pharm.D. degree.

A title is . . . a distinctive designation or a descriptive name, given to persons by virtue of rank, office, or privilege; or as a mark of respect.

WHAT'S THE ANSWER?

The Board of Directors has voted to change the designation from R.Ph. to P.D. The designation will carry with it the title "Doctor of Pharmacy." Pharmacists are *not registered* they are *licensed* and this makes R.Ph. totally wrong no matter how "comfortable" some of us have become with this inaccurate designation.

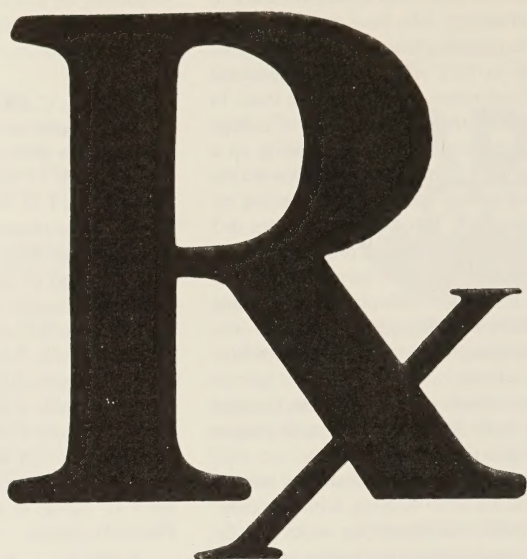
It may be interesting to note that the legal profession did almost exactly what we are proposing. They even went, as we are doing, back into the past and chose the designation J.D. (Juris Doctor) which had been suggested as early as 1904.

Some may accuse pharmacists of just wanting more prestige or even being on an ego trip. Let them say what they want. We want and need uniformity in professional titles as granted to all other health care professionals. Isn't it interesting, that the people who tell us there is "nothing in a title" are the people who already have the title.

SUMMARY

A review of the past and present circumstances surrounding pharmacy education and the dual degrees now being offered, and the fact that all schools will almost certainly one day be granting only a doctors degree, leads to only one conclusion.

Our profession must do as other professions have done and adopt a uniform designation that accurately identifies its practitioner, and carries with that designation the title of "Doctor."



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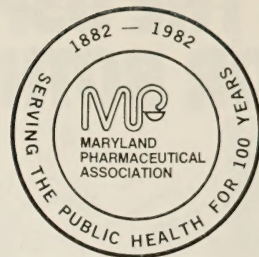
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A Century of American Pharmacy

by
David L. Cowen



This series of articles has been contributed by the American Institute of the History of Pharmacy in commemoration of the centennial of the Maryland Pharmaceutical Association. While the centennial is still a year away, the Centennial Celebration Committee is working now to acquaint pharmacists with their professional heritage.

Pharmacy in the United States developed within the constantly changing pattern of American history and American culture; it did not develop *in vacuo*. The formation of the Maryland Pharmaceutical Association, for example, was an indication of the growing complexity, if not maturation, in American life that made the ante-bellum Jacksonian democratic notions no longer viable. In the 1870's and 1880's little groups of pharmacists, now rejecting the proposition that it was the "privilege" of "men to dose themselves with medicines at the hands of ignorant and unskilled persons," were able to convince state legislatures that it was no longer tenable, as it had been twenty-five years earlier, that in a "Republican Government like ours every man had the right . . . to follow whatever occupation or profession (is) most congenial to his feelings." Licensing laws in medicine and dentistry, as well as in pharmacy, became as common in the late nineteenth century as they had been scarce before the Civil War. Similarly, the constant struggle of pharmacy to protect both its art and its financial well-being reflected the impact of rapid urbanization and industrialization, big business, and national advertising on the American economy and society.

At the end of the Civil War pharmacy found itself undergoing a metamorphosis. The pharmacist was still making up his own elixirs and tinctures, he (or his clerk) spread plasters, he ground crude drugs, he made his extracts and percolates, he made his pills and powders, and, of course, he compounded *secundum artem* the prescriptions brought into his shop.

As well, the drug department of his shop carried herbs and roots which he sold, in their crude state, to his patrons. It also contained a collection of nostrums like seneca oil, oil of tar, and bear oil, and more significantly, an increasingly extensive array of proprietary remedies.

The last was to be particularly significant, for these, and the new chemical substances finding their way into the prescription department, meant that the pharmacist was increasingly finding himself handling products that others had made.

The growing industrial complex, able to surpass the pharmacist at his own art, and threatening, especially through the proprietary process, to denigrate his importance, was but one of the forces at work changing the patterns of pharmacy. Another, and one perhaps by its nature more noticeable and immediate, was the increasing competition from untrained sellers of drugs, who, in the absence of restraints of any kind, threatened both the economic interests of pharmacy and the public well-being. The last was at the expense of the reputation of pharmacy and entailed not only public criticism but even more significantly the antagonism of the medical profession. The only response to this situation was organization and legislation, and since under the American constitutional system the state was the proper level of government at which to seek reform and redress, it behooved American pharmacy to seek to organize state associations.

Thus, in 1868-1869, the American Pharmaceutical Association, and particularly its Secretary, John M. Maisch, took up the task of sponsoring and supporting state legislation, and as an essential prerequisite for it, the creation of state associations. For the most part, the sudden flowering of state pharmaceutical associations — they were called, in 1884, the "children of the American Pharmaceutical Association" — was the culmination of this effort. By 1879, 19 states had organized state associations; Maryland was one of fourteen more to do so by 1883; by the end of the century a total of 46 states and territories had pharmaceutical associations.

Not all of these associations were "children" of the American Pharmaceutical Association, however. New Jersey, North Carolina and Mississippi associations, for example, came into existence to forestall legislation that would have placed pharmacy under the control of the medical profession. The Maryland Pharmaceutical Association came into existence through still another route — the initiative of the Maryland College of Pharmacy. (This points up the fact that the early colleges of pharmacy in this country, of which Maryland was one, were in fact professional associations of local pharmacists, education being but one of their functions.)

The last 100 years have therefore been a time of *organized* pharmacy in the United States. Through organization pharmacy has sought three general goals: the improvement of the scientific and professional status of pharmacy, the protection of the economic interests of pharmacy, and the restriction of the practice of pharmacy to qualified practitioners.

State Boards of Pharmacy

There is very evident relationship between the establishment of state pharmaceutical associations and the enactment of pharmacy laws requiring the examination and licensing of pharmacists. Yet it was not always easy to convince state legislators of the desirability of establishing state boards of pharmacy and placing restrictions on who might practice pharmacy. Although state-wide legislation antedated the founding of state associations in a few states (Florida, Louisiana, and Rhode Island, for example), and legislation followed the founding of state associations by a year or two in other states (Illinois, Minnesota, Missouri, New Hampshire, North Carolina, Oregon, West Virginia, and Wisconsin, for example), for the most part it took several years for the state associations to get the legislation they sought. Six states (California, Maryland, Mississippi, New York, Tennessee and Vermont) took over 20 years to get state-wide legislation passed, although the first four of these had laws regulating pharmacy in selected local jurisdictions. (Maryland had a law regulating pharmacy in Baltimore that dated from 1870 and not state board until 1902. That state board did not have jurisdiction over Talbot County until 1906 and not until 1908 could a licensee of the state board practice in any county of the state.)

The legislation which was placed on the statute books of the states and territories in the last three decades of the nineteenth century was guided by a model law drafted primarily by Maisch. Later, early in this century, the American Pharmaceutical Association suggested a revised model

law (the work of James H. Beal). This legislation established the basic principle that pharmacy should be self-regulating: the state boards of pharmacy were to be comprised of pharmacists, usually nominated to the governors by the state associations. Only in very recent years has this principle been challenged; state boards of pharmacy are no longer completely independent of the law enforcement agencies of the state governments and there is increasing pressure to place non-professionals on the boards.

In any case, the legislation has placed control of examination, licensing, and registration of pharmacists and Pharmacies in the hands of the boards. Legislation at the same time set educational and experience requirements; established rules for the dispensing of poisons, and later for the dispensing of narcotic, barbiturate, and dangerous drugs; proscribed the sale of adulterated drugs; and wrote certain ethical standards into law, such as the proscription of substitution. Maryland, to illustrate, in two separate acts passed a poison law and an anti-substitution law in the same year, 1902, that the state board of pharmacy was created. In short, pharmacy became a regulated profession, hardly as controlled as on the European continent, but nevertheless no longer existing under a complete system of free enterprise. Moreover, the self-policing powers of the state boards — they were given powers of inspection and of discipline, and even revocation of license — were premised on the responsibility of pharmacy to the public; pharmacy was a health profession.

(to be continued)



Can anyone identify the year of this early MPhA convention? Location?

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Health Maintenance Organizations

(HMOs)

In Maryland

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Pharmacy Student Extern in
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Balto., MD
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- (5.) CONSTANT CARE:
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- (6.) EAST BALTIMORE MEDICAL PLAN
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1000 East Eager Street
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Dana Inglesby Phone: 277-6520
6611 Kenilworth Ave.
Riverdale, MD 20840
Pharmacy Services: Network system involving both
chains and independents. Not medicaid approved.
- (10.) MD-IPA
Mary Williams Phone: 762-8205
Suite 600
451 Hungerford Dr.
Rockville, MD 20850
Pharmacy Services: Network system with pharmacies
in the area. This is done via a contractual agreement.
They are not yet medicaid approved.
- (11.) MONUMENTAL HEALTH PLAN
Ms. Briscoe Phone: 624-7600
2300 Garrison Blvd.
Suite 150
Balto., MD 21216
Pharmacy Services: In-house pharmacy. Is medicaid
approved.
- (12.) SOUTH COUNTY FAMILY HEALTH CARE
CORP.
Ms. Debbie Williams, Director of Nursing Phone: 841-6064

2568A Riva Rd.
Anne Arundel, MD 21401

Pharmacy Services: They have in-house pharmacists at two of their sites. If the patient is at either site when given the prescription, then they get it filled at the pharmacy there. If not, they can get it filled at the community pharmacies in that area. However, there are no formal, contractual agreements between these community pharmacies and the HMO. They are medicaid approved.

Those with licenses pending in the state of Maryland:

(1.) DELMARVA HEALTH PLAN:

Peter Brochart, Director
108 N. Harrison Street
Easton, MD 21601

Phone: 822-7223

Pharmacy Services: Pharmacy is not part of the basic benefit plan; rather it is a rider option. No formal plans have been made concerning the structure of the pharmacy services. It will depend to a large extent on the number of subscribers choosing this option. They are not medicaid approved.

(2.) FREE STATE:

Sharon Straw
7800 York Rd.
Towson, MD 21204

Phone: 494-5001

Pharmacy Services: Some in-house at certain centers. Other centers have a network system of pharmacies in the area. One of their centers in particular deals exclusively with GIANT (see Clinical Association . . . No. 3). They are not medicaid approved.

(3.) HEALTH PLAN OF ANNE ARUNDEL COUNTY:

Ms. Herring
2510 Riva Road
Suite 200
Anne Arundel, MD 21401

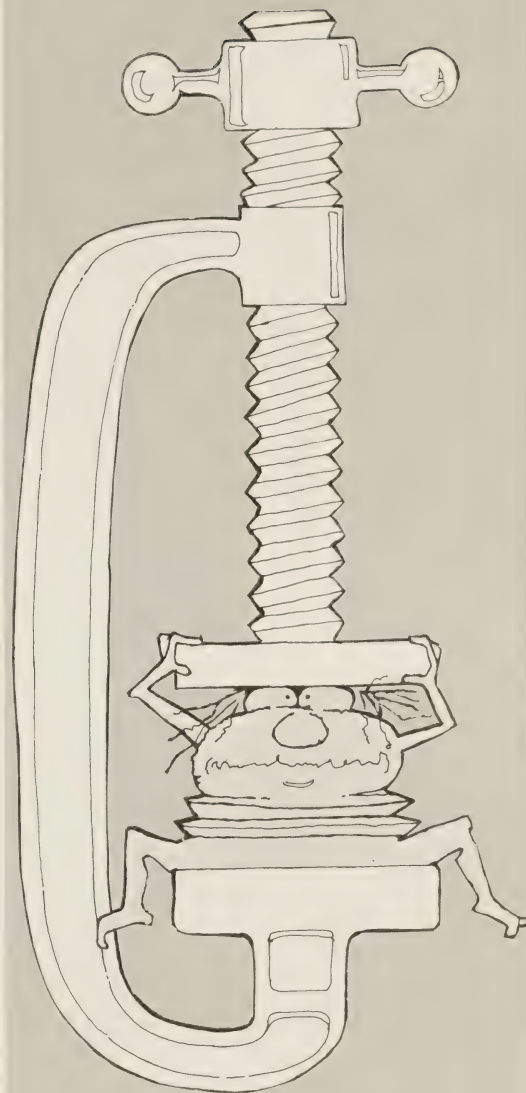
Phone: 266-6255

Pharmacy Services: Not yet operational. Will have an out of house pharmacy system, but they are not sure how they plan to operate it yet. They are not medicaid approved.

IMPORTANT NOTE: Article 48A of the Insurance Code, part 20 — Nonprofit Health Service Plans, Under Section 354, part b., states:

“Any nonprofit health plan which provides pharmaceutical services shall grant to any subscriber, member or beneficiary the right to have any prescription filled at the pharmacy of the subscriber's, member's, or beneficiary's choice.”

Complaints involving this section of the law should be brought to the attention of the Association and the Insurance Commissioner.





Kathryn E. Borer

Ohio Northern University

Sharon M. Emanuel

University of Nebraska

Carol Fowler

University of Oklahoma

Steph Stullidge

University of South Carolina

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And reminiscing about the summer of '80.

Upjohn

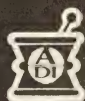
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Name

Address

City

State

Zip

Contract Managed Pharmaceutical Services in Institutions

by: Lucy Mellington, Senior Student, University of Maryland, School of Pharmacy
Developed to meet, in part, requirements of PPAS 454, Inst. Pharm. I

I. IMPORTANCE

- A. Continuing pressure from government to decrease health care costs is leading to an increase use of contract services.
- B. There is a growing increase in the sophistication of pharmaceutical services therefore in management also. Need for management specialists.
- C. Hospitals view drug distribution as a pharmacy function only not a hospital-wide function. Contract services may aid in the implementation of new systems which decrease error rates and increase the quality of health care. Involve MDs, nurses as well as pharmacists in drug distribution.
- D. May offer resources for recruitment of better directors of pharmacy.
- E. Good pharmacy management is very important in the successful operation of hospitals in general.

II. PREVALENCE

17 firms hold 400-500 contracts with hospitals in the U.S.
Less than 10% of hospitals in the U.S. use contract pharmaceutical services.
All firms are showing significant annual growth rates

III. SERVICES PROVIDED

- Hospitals are offered a wide variety of services compared to the past
- Services range from complete pharmacy management to short term consultations.

A. Complete Management

- 1. Firm purchases entire inventory, supplies, fixtures and equipment
- 2. All personnel are transferred to firms payroll and trained
- 3. Additional personnel are supplied by the firm as needed.
- 4. Firm is responsible for new equipment, training, inventory, remodeling and employee benefits.
- 5. Implement a drug distribution system which is cost effective and efficient within the hospital. Complete management services more beneficial and usually recommended for smaller institutions.

B. Consultant Services – Short term or permanent

- 1. Time management skills
- 2. Productivity management
- 3. Use of computers
- 4. Personnel Management

- 5. Quality assurance
- 6. Drug Utilization Review
- 7. Budgeting

It is more beneficial for larger institutions to use consultants and learn to run their pharmacies more effectively and efficiently than to contract full management services. Is More cost effective also..

C. Clinical Pharmacy Consultant Firms

- 1. Drug monitoring for therapeutic effectiveness
- 2. Drug regimen reviews
- 3. Drug utilization reviews

D. Other Services

- 1. Drug education — examples — Pharmacology for nurses
Continuing education for pharmacists
- 2. Staff Training Programs.
- 3. Newsletters
- 4. Quality assurance programs

IV. Appropriateness and Effect on the quality of service

Terms — Appropriateness — 5 characteristics
(Availability, cost, continuity, quality, acceptance)
Quality — appropriate, effective and efficient services

A. Availability

— Refer to prevalence and services provided

B. Cost

- 1. Decreasing costs
- 2. Example provided of how one firm decreased cost through implementation of unit dose system and increased inventory monitoring.

C. Continuity

Statistical annual growth rates in present firms

D. Quality

- 1. Means of increasing quality
 - a. Implementation of unit dose systems
 - b. Consultation services
 - c. Quality assurance programs
- 2. Example provided of HPI's quality assurance program

V. Employment opportunities

A. Competitive salaries

B. Positions within firms

Includes staff pharmacists, directors of pharmacies, clinical pharmacists, Management within the firm, Conducting training programs.

COMPANIES OFFERING CONTRACTUAL PHARMACY SERVICES

Advanced Health Systems, Inc.
881 Dover Dr.
Ste 20
Newport Beach, Ca. 92663
(714) 645-4310

American Pharmacy Corp.
3800 Buffalo Speedway
Ste. 400
Houston, T. 77098
(713) 621-4539

A.E. Brim & Associates, Ltd.
137 N.E. 102nd Avenue
Portland, Or. 97220
(503) 256-2070

Charter Medical Corp.
P.O. Box 209
Macon, Ga. 31202
(912) 477-5050

HPI
10960 Wilshire Blvd.
Ste. 2000
Los Angeles, Ca. 90024
(213) 473-6771

National Data Corp.
One National Data Plaza
Corporate Square
Atlanta, Ga. 30329
(404) 329-8500

The Owen Co.
Ste. 726
8181 Commerce Park Dr.
Houston, Tx. 77036
(713) 777-8173

Pharmaceuticals Management, Inc.
Div. of Hyatt Medical Mgt. Services Inc.
12626 Riverside Drive
Ste. 103
North Hollywood, Ca. 91607
(213) 984-2272

Pharmacy Systems, Inc.
3366 Riverside Drive
Columbus, Ohio 43221
(614) 451-0171

Pharmaceutical Services Industries, Inc.
01681 Gulf Blvd.
Ste. 201
Treasure Island, Fla. 33706
(813) 360-1822

Owens a network of 10 special hospitals, 12 professional practices, and one health center. Offer short term consultation projects and long term adm./mgt. contracts.

Offers contract clinical pharmacy services. Handles Medical histories, patient profiles, unit dosing, in service programs, TPN.

Contract Management services to small rural hospitals and long term care facilities

Full Hospital management services, national purchasing program, 3rd party reimbursement management.

Offers contract pharmacy and central services. Unit dose, IV admixture. Largest Co. at present.

Offers completely computerized total pharmacy management system, handling inventory, pricing and 3rd party reimbursement billing.

Contractual pharmacy services. Unit dose, IV admixture. Guarantees a net profit to the hospital from pharmacy operations.

Contractual pharmacy services. Unit dose, IV admixture. Charge recovery system.

Contractual pharmacy services. Unit dose, IV admixture. Hosp. retains administrative and financial control.

Contract pharmacy services to hospitals and nursing homes. Consultation services following pharmacy audit.

REFERENCES

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- Hepler C. D. *Yesterday's mashed potato: theory, practice, and change in institutional practice management* PM 151(1):19-21 Jan.-Feb. 79
- Managers improve MD and nurse drug education Mod Health Care 8(7):50,52 July 78
- Design and implementation of a quality-assurance program for pharmaceutical services.* Am J Hosp. Pharm. 37(1):82-4 Jan. 80
- Drug regimen review in skilled nursing facilities by consulting clinical pharmacists* Am J Hosp. Pharm. 37(6):820-4 June 80
- List of companies offering contractual pharmacy services provided from Pharmacy 454 file. Ref: Stein, L. *Who's who in management and contract services* Health Care Product News Feb. 78

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business does
a handsome dog
like me have
with a
top cat
like you?**



My name's McGruff, and it's my business to help prevent crime. I think it should be your business, too—to teach your employees how to protect themselves. Just send for my business kit—it'll help you develop a program that teaches your employees how to make their homes burglar-proof, make their neighborhoods safer, even how not to get mugged.

And, while you're at it, get in touch with the cops—they can help you out. So now you're probably wondering (like a top cat businessman should), what's in it for you. That's easy. When your company works harder for your people, your people work harder for your company.

So take the time, and...

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CRIME**

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A message from the Crime Prevention Coalition, this publication and The Ad Council

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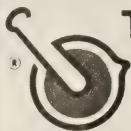


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Al Turner

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Neil Smith

BMPA Installs New Officers

Mr. Abe Bloom, whose company, Paramount Photo Service, donates this page to the Journal, was elected as the 1980-81 Honorary President of the BMPA at its annual Meeting November 6, 1980 in the Kelly Memorial Building.

In-Coming President Joe Loetell is shown shortly after receiving the gavel of office from installing officer and Treasurer Charles Spigemire. Other officers who were installed were: Frank Marinelli, President-elect; Samuel Lichter and James Culp, Vice Presidents; and Ralph Quarles, Chairman of the Board of Trustees. Other Board Members are: Ralph Small, Elwin Alpern, Morty Silverstein, Mark Levy, Howard Schiff, Marty Mintz, David Greenfeld, Norma Schapiro, George Voxakis and John Ayd.

James Culp (left) and Charles Powell (right) stand during the officer discharge ceremony.



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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

DES:

The estrogenic substance, diethylstilbestrol, is still being used to increase the rate at which food animals gain weight. This has been forbidden since November 1, 1979, but apparently inspectors are still finding evidence of DES use. Animals found to have evidence of DES use are held for at least 41 days in order to allow the drug to be adequately removed from the body. *J AM MED A*, Vol. 244, #3, p. 288, 1980.

ASPIRIN:

Aspirin in various dosage forms was administered to several groups of volunteers in doses of approximately 4 grams/day. After seven days, endoscopic evaluation of gastric and duodenal mucosa indicated no difference between the degree of irritation produced by aspirin (Bayer) and buffered aspirin (Ascriptin A/D). Enteric coated aspirin did not produce any obvious irritation. *N ENG J MED*, Vol. 303, #3, p. 136, 1980.

CHILDHOOD ASTHMA:

A group of 400 children were studied to determine the effect of age on childhood asthma. Children who were wheezing before the age of 7 years were included in the group. Approximately 55% of those subjects improved dramatically before adolescence. A few experienced some minor recurrence until age 21 years. Girls did less well during adolescence than boys, but most improved before adulthood. *BR MED J*, Vol. 280, #6229, p. 1397, 1980.

SUPROFEN:

Another peripheral analgesic, suprofen, is being used experimentally to determine if it will have a place in the modern day practice of medicine. The non-steroidal anti-inflammatory drug produces its activity by inhibiting the tissue synthesis of prostaglandins. The activity of the drug is not reversed by narcotic antagonists. *J PHARM EXP*, Vol. 214, #1, p. 16, 1980.

ACETAMINOPHEN-ETHANOL:

Acetaminophen produces hepatotoxicity which can lead to hepatic coma and death. Alcohol is also capable of causing liver damage and it seems that each drug is capable of potentiating the hepatic toxicity produced by the other. Animals pretreated with ethanol have less tolerance to acetaminophen and it has been noted that alcoholics suffered toxicity from acetaminophen at doses not generally associated with hepatic toxicity. *J AM MED A*, Vol. 244, #3, p. 251, 1980.

PROPRANOLOL AND PRAZOCIN:

Propranolol (Inderal) and prazosin (Minipres) were administered alone and in combination to determine the effects of the different regimens on the concentration of plasma lipids. Propranolol, when used alone, caused a general reduction in the concentration of cholesterol, but increased the concentration of both triglycerides and uric acid. Prazosin caused a reduction in both cholesterol and triglycerides. The combination regimen produced some slight changes in plasma lipids, but uric acid levels remained at a high-normal level. Addition of a thiazide diuretic to the regimen, as is often done, may be sufficient to produce hyperuricemia. *LANCET*, Vol. II, #8184, p. 4, 1980.

BICARBONATE AND BLOOD COAGULATION:

The addition of either sodium or potassium bicarbonate to fresh human blood obtained from healthy volunteers was found to inhibit the normal clotting of blood. There was an increase in the prothrombin time and thrombin clotting times. This evidence supports clinical observations which also suggest the presence of an anticoagulant effect in the presence of alkali. *J AM MED A*, Vol. 244, #1, p. 61, 1980.

INDOBUFEN:

Indobufen is another NSAID capable of inhibiting prostaglandin synthesis. The drug may be useful in treating thrombotic disease states. *J CLIN PHAR*, Vol. 20, #5, part 1, p. 316, 1980.

MIGRAINE HEADACHE:

Many causes have been given for the migraine headache, but investigators in Great Britain feel it may be due in part to an allergy to specific foods. Patients who experience severe migraine headaches generally can be shown to be allergic to certain foods. It is felt that the initial specific allergic reaction in the gastrointestinal tract may increase mucosal permeability, and allow for food antigens, complexes or mediators to be absorbed. These could cause the headache to start. Administration of oral cromolyn sodium (Intal) protected these patients from a headache challenge produced by foods to which they were allergic. The test to determine susceptibility to food allergy is called the radioallergen sorbent test (RAST). *LANCET*, Vol. II, #8184, p. 1, 1980.

POSTMENOPAUSAL OSTEOPOROSIS:

Endogenous estrogens apparently prevent osteoporosis during the premenopausal state, but after estrogen secretion decreases, the bone disease becomes more common. Using supplemental estrogen therapy, physicians have been able to prevent further bone deterioration, but it also seems to increase the likelihood of endometrial hyperplasia and carcinoma. A new compound has been found which has only weak estrogenic activity but does seem to prevent the decomposition of bone. Initial trials suggest that it may be useful in preventing post climacteric osteoporosis. *BR MED J*, Vol. 280, #6225, p. 1207, 1980.

METYROSINE:

In an attempt to block the synthesis of norepinephrine in the terminal adrenergic neuron, methyl dopa was synthesized. Initial tests showed it capable of reducing blood pressure and many investigators felt that the effect was mediated through its ability to block the enzyme pathway responsible for catecholamine synthesis. Subsequent experiments have shown that the drug does not really work through this mechanism, but acts as a false transmitter to inhibit activity within the central nervous system. A new drug, metyrosine, has been shown to inhibit the enzyme system. The drug was also known as alpha methyl tyrosine and will be marketed under the trade name Demser by Merck, Sharpe and Dohme. *J CLIN PHAR*, Vol. 20, #5, part 1, p. 371, 1980.

LIDOCAINE DETERMINATIONS:

Lidocaine is a very useful antiarrhythmic agent but toxicity is seen in approximately 6 to 20% of the patients receiving the drug. One drawback has been associated with administration of the drug and that deals with the problems met when one tries to accurately and rapidly determine plasma concentrations of the antiarrhythmic agent. A new method of analysis called EMIT (rapid enzyme immuno assay technique) has been designed to allow clinicians to receive accurate plasma levels of lidocaine within one hour. This procedure will undoubtedly help maintain a higher degree of control of drug concentrations in seriously ill patients. *J AM MED A*, Vol. 244, #6, p. 571, 1980.

MEVALONIC ACID METABOLISM:

Mevalonic acid is an essential intermediate in the synthesis of sterols. The compound is metabolized to either cholesterol or carbon dioxide. Studies conducted in human volunteers indicate that men will convert more mevalonic acid to cholesterol than will women. The full impact of this finding is not yet evident, but it may help explain the high incidence of hyperlipidemia seen in males under the age of 45 years. *J CLIN INV*, Vol. 66, #2, p. 361, 1980.

INTRAVENOUS INTROGLYCERIN:

More use is being made of continuous intravenous drips containing nitroglycerin. Some loss of potency has been noted and larger than average doses have been required to achieve the desirable hemodynamic effects. Studies show that the antianginal agent is adsorbed by the plastic components in the IV bag, burette, and tubing. Similar findings have been noted when insulin, vitamin A or diazepam are used in plastic containers. Other drugs may also be adsorbed by plastic ware and one should be constantly alert to this possibility. *J PHARM PHA*, Vol. 32, #4, p. 237, 1980.

PROPRANOLOL:

Excessive thyroid gland activity has been lessened with the use of propranolol (Inderal) because it is capable of decreasing adrenergic activity associated with hyperactivity of the gland. In addition to blocking this action, propranolol is apparently capable of preventing the conversion of T-4 to T-3 in the periphery through a mechanism that is not associated with beta-adrenergic blockade. It is the T-3 form of thyroid hormone which is thought to be responsible for producing the actual regulation of cellular metabolism. *BR MED J*, Vol. 271, #6232, p. 24, 1980.

CERVICAL CANCER:

Cervical cancer will often follow the development of cervical dysplasia. In order to help reduce the risk of neoplastic growth, women taking oral contraceptives who develop cervical dysplasia were given folic acid (10 mg daily) for three months. This regimen seemed to reduce the progress of the dysplasia and may have acted to prevent the development of a neoplastic growth. *J AM MED A*, Vol. 244, #7, p. 633, 1980.

calendar



- Jan. 22 — PharmPAC meeting — 9 p.m. Pikesville Quality Inn
- Feb. 8 — BMPA — Annual Dinner Dance — Bluecrest, Reisterstown Rd.
- Feb. 26 — CECC Program — "Geriatrics" — Baltimore Convention Center
- Mar. 5 — SAPH A C.E. program — "Computers in Pharmacy", Holiday Inn, Cromwell Bridge Rd.
- Mar. 12 — MPhA Spring Regional Meeting
- Mar. 19 — CECC Program — "Primary Care" — Kelly Memorial Building
- Mar. 22 — Fritz Berman Seminar — "Psychiatry, Neurology and the Pharmacist"
- Mar. 28-Apr. 1 — APhA Annual Meeting in St. Louis
- Jun. 19-21 — MSHP Annual Convention — Ocean City
- Jun. 21-25 — MPhA CONVENTION — OCEAN CITY

Every Sunday Morning at 6:00 a.m. listen to Charles Spigelmirre on WCAO broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore.



The University of Maryland School of Pharmacy announces the appointment of Dr. Naim Khazan, professor and chairman of the Department of Toxicology to Emerson Professor in Pharmacology. The endowed chair was established 50 years ago by Captain Isaac Emerson, the druggist who made Bromo Seltzer. As the fourth Emerson Professor, Dr. Khazan and his research on experimental drug dependence with opiates and opioids, are awarded distinguished recognition.



Pharmacists from all over the State gathered at a recent meeting in the Kelly Building to discuss the third party crisis that afflicts pharmacy owners. While the Association is enjoined by the antitrust laws from taking joint action (see the November 1980 issue of the journal for a complete discussion), the Association continues to pursue all legal avenues in this area.

Lilly Digest figures for South Atlantic States

(Show this to your friends who think Pharmacists are getting rich)

	1979 SOUTH ATLANTIC STATES (175 Pharmacies) (175 Pharmacies)	1978 SOUTH ATLANTIC STATES (192 Pharmacies) (192 pharmacies)	1979 UNITED STATES AVERAGE (1,458 Pharmacies) (1,458 Pharmacies)
AVERAGES PER PHARMACY			
SALES			
Prescription	\$ 211,231 — 52.8%	57.2%	49.8%
Other	189,154 — 47.2%	42.8%	50.2%
Total	\$ 400,385 — 100.0%	\$ 333,800 — 100.0%	\$ 391,681 — 100.0%
COST OF GOODS SOLD			
	262,864 — 65.7%	65.4%	65.7%
GROSS MARGIN			
	\$ 137,521 — 34.3%	34.6%	34.3%
EXPENSES			
Proprietor's or manager's salary	\$ 26,750 — 6.7%	7.2%	6.5%
Employees wages	50,432 — 12.6%	11.8%	11.9%
Rent	8,696 — 2.2%	2.2%	2.5%
Miscellaneous expenses	40,677 — 10.1%	10.2%	10.4%
TOTAL EXPENSES	\$ 126,555 — 31.6%	31.4%	31.3%
NET PROFIT before taxes)			
	\$ 10,966 — 2.7%	3.2%	3.0%
TOTAL INCOME OF SELF-EMPLOYED PROPRIETOR (before taxes on income and profit)			
	\$ 37,716 — 9.4%	10.4%	9.5%
VALUE OF INVENTORY AT COST AND AS A PERCENT OF SALES			
Prescription	\$ 24,098 — 11.4%	11.6%	11.8%
Other	\$ 41,126 — 21.7%	21.0%	20.9%
Total	\$ 65,224 — 16.3%	15.6%	16.4%
ANNUAL RATE OF TURNOVER OF INVENTORY			
	4.2 times	4.3 times	4.2 times
NUMBER OF PRESCRIPTIONS DISPENSED			
New	15,621 — 49.2%	48.7%	49.7%
Renewed	16,100 — 50.8%	51.3%	50.3%
Total	31,721 — 100.0%	100.0%	100.0%
PRESCRIPTION CHARGE			
	\$6.66	\$6.20	\$7.18
NUMBER OF HOURS PER WEEK			
Pharmacy was open	63 hours	63 hours	64 hours
Worked by proprietor	45 hours	42 hours	47 hours
Worked by employed pharmacist(s)	38 hours	29 hours	37 hours

(Source: 1980 Lilly Digest)

The Industry Relations Committee Says:

Make February The Month You Clean Out Dated Merchandise

The Industry Relations Committee of the Maryland Pharmaceutical Association formed a subcommittee to study the issue of a Model Return Goods Policy. It was the feeling of the Committee, which is made up of manufacturing representatives and practicing pharmacists, that the policy should be fairly comprehensive and yet, provide some guidance and consistency in this area. The goal of the Committee was to develop a policy which could be endorsed by the Association in an attempt to establish a standard and which would be acceptable to both manufacturers and retailers.

The Committee recommends that members retain this page from the journal and refer to the following MPhA adopted policy whenever a question concerning returning merchandise arises. In addition, the Industry Relations Committee serves as an ombudsman whenever members refer a problem concerning this subject in writing to it.

MODEL RETURN GOODS POLICY

1. New prescription drug products shipped to the pharmacy automatically by the manufacturer or wholesaler may be returned at any time for credit or exchange.
2. Regardless of expiration dates products may be returned for credit or exchange at any time, providing they are sealed, intact, original packages.
3. For patient protection, open packages of prescription drug products which are outdated may be returned for at least partial credit.
4. Authority for returns may be required by the pharmaceutical manufacturer or wholesaler—a form should be provided to the pharmacy.

SAMPLE FORM to Return Merchandise

TO: (Name of Manufacturer)
Address — including the name of Town, County,
State and Zip Code

(Note — the above as well as the policy for making returns may be located in the NWDA list of Mfgs. in January 1977 edition of the American Druggist Blue Book.)

Please grant us authorization to return the following pharmaceuticals of your manufacture as per your policy:

It is best to list the items — listing complete packages as well as open containers. If a return of a schedule 2 is requested, be sure to give exact count and hold these aside as they usually will send a narcotic form. (Because of mail rates, it may be less expensive to have the drug inspectors destroy them.)

Note — If in their reply, they say they do not accept open containers — or — partially filled ones, call their attention to the fact that for the protection of the patient, as well as the pharmacist and the manufacturer, you believe it best they change their policy to permit them to accept them for credit.





Michael L. Fisher, M.D., Associate Professor of Medicine at the University of Maryland School of Medicine, was one of several outstanding speakers at the Henry G. Seidman Memorial Seminar on "Cardiovascular Diseases and their Treatment."



The Seminar was sponsored by the Maryland Pharmacy Continuing Education Coordinating Council and was held on November 1, 1980.



Freda Seidman receives the First Annual "Pharmacist of the Year" Award in the name of her husband from M.P.H. President Samuel Lichter (hidden). David Rothman, Pharm.D. (right) serves as Chairman of the Seidman Memorial Fund.



Sam Lichter also served as moderator for the all-day seminar which was held in the Kelly Memorial Building.

OTC Education Brochure is Available

The National Association of Retail Druggists (NARD) and The Proprietary Association (PA), representing the manufacturers of nonprescription medicines, today announced a joint consumer education program that will stress the importance of the pharmacist as a further source of OTC medicine information.

A counter card depicting a typical OTC label with a description of the type of information available will carry the message, "Nonprescription medicine is serious medicine! So always **READ THE LABEL** and ask your pharmacist if you still have questions."

Copies of "Medicine Labels and You," a PA brochure providing additional information about product labels, will be available in a pocket on the counter card for easy consumer access. The counter cards will be offered to some 75,000 pharmacists throughout the country.

"Pharmacists are drug experts and one of the most accessible sources of information," stated William E. Woods, NARD's Executive Vice President. "We hope," said Woods, "that this program will further stimulate discussion between pharmacists and consumers." "Many new products and reformulated ones are appearing on the market as a result of the FDA's review of OTC ingredients," said

Woods, adding: "This increases the consumer's need for more information. We are confident that this program will help provide that information and educate consumers regarding the care necessary in selecting and using nonprescription drugs compatible to their special needs."

James D. Cope, PA President, added: "In this age of soaring health care costs and the emphasis on self-reliance in matters of health, people are turning more and more to self-medication. Industry has, for a number of years, conducted a wide-ranging public education campaign to encourage more and better readership of labels. We are especially pleased to be a part of this cooperative effort with pharmacists. We see it as a new and important step in providing consumers with even more of the information they need to practice responsible self-medication."

Additional information about the project is available from Cathy Sulzberger, NARD, (202) 347-7495 or Jackie Maio, PA, (202) 393-1700. Anyone interested in ordering the counter card and brochures can write directly to NARD, 1750 K Street, Suite 1200, Washington, D.C. 20006. (There will be a handling charge of \$1.50 for each order.)

Medical Assistance Patients

(Medicaid, Pharmacy Assistance Programs)

There are some restrictions in the State Program which the Pharmacist will be glad to explain to you.

Some of the rules which the State has made are:

- ☐ YOU MUST HAVE A NEW, SIGNED PRESCRIPTION FROM THE DOCTOR FOR EACH NEW PRESCRIPTION.
- ☐ YOU MUST PRESENT YOUR PLASTIC CARD EACH TIME.
- ☐ THE PRESCRIPTION SHOULD BE ON A SPECIAL STATE FORM.
- ☐ WITH ONLY A FEW EXCEPTIONS, SUCH AS INSULIN, YOU WILL HAVE TO PAY FOR ANYTHING THAT CAN BE BOUGHT WITHOUT A PRESCRIPTION, EVEN IF THE DOCTOR WROTE A PRESCRIPTION.
- ☐ YOU WILL HAVE TO PAY FOR DIET PILLS.
- ☐ THE PRESCRIPTION MUST BE FILLED WITHIN 10 DAYS OF THE DATE THE DOCTOR WROTE IT.

YOU ARE ALLOWED UP TO TWO REFILLS IF:

1. The Doctor wrote it on the original prescription.
2. The prescription plus refills are not more than 100 day supply.
3. You get the refills all within 100 days of the day the Doctor wrote it.
4. You present an in date plastic card when you ask for the refill.

- ☐ YOU MUST PAY 50¢ FOR EACH MEDICAID PRESCRIPTION FILLED AND \$1.00 FOR EACH PHARMACY ASSISTANCE PRESCRIPTION FILLED.
- ☐ IN SOME CASES WE WILL HAVE TO GIVE A DIFFERENT BRAND OF THE SAME MEDICINE THAN THE DOCTOR ORDERED.
- ☐ VERY EXPENSIVE DRUGS WILL HAVE TO BE AUTHORIZED BY THE STATE. WE MAY HAVE TO GIVE YOU A SMALL QUANTITY UNTIL WE CAN GET THE STATE APPROVAL.

**IF YOU ARE JUST STARTING ON THE PROGRAM,
YOU MUST GET ALL NEW PRESCRIPTIONS WRIT-
TEN BY YOUR DOCTOR ON A SPECIAL STATE
FORM.**

POISONOUS PLANTS

COMMON NAME	BOTANICAL NAME	COMMON NAME	BOTANICAL NAME
Amaryllis	<i>Hippeastrum equestre</i>	Jack-in-the-Pulpit	<i>Arisaema triphyllum</i>
Autumn crocus,	<i>Colchium autumnale</i>	Jequirity bean	<i>Abrus precatorius</i>
Meadow saffron		Jerusalem Cherry	<i>Solanum pseudocapsicum</i>
Azalea	<i>Rhododendron</i> spp.	Jimson Weed	<i>Datura stramonium</i>
Baneberry	<i>Actaea</i> spp.	Jonquil	<i>Narcissus jonquilla</i>
Barberry	<i>Berberis vulgaris</i>	Lantana	<i>Lantana</i> spp.
Bittersweet, American	<i>Celastrus scandens</i>	Ligustrum	<i>Ligustrum</i> spp.
Bittersweet, European	<i>Solanum niger</i>	Lily-of-the-Valley	<i>Convallaria majalis</i>
Black Locust	<i>Robinia pseudoacacia</i>	Lobelia	<i>Lobelia</i> spp.
Black Nightshade	<i>Solanum niger</i>	Mayapple	<i>Podophyllum peltatum</i>
Bleedingheart	<i>Dicentra</i> spp.	Mistletoe	<i>Phoradendron flavescens</i>
Boxwood	<i>Buxus</i> spp.	Monstera, Ceriman	<i>Monstera deliciosa</i>
Bracken fern	<i>Pteridium aquilinum</i>	Mountain Laurel	<i>Kalmia latifolia</i>
Burning Bush	<i>Euonymus atropurpureus</i>	Mushrooms,	<i>Nary species are poisonous.</i>
Buttercup	<i>Ranunculus</i> spp.	Toadstools	
Caladium	<i>Caladium</i> spp.	Narcissus	<i>Narcissus</i> spp.
Cardinal Flower	<i>Lobelia cardinalis</i>	Nephrhytis,	<i>Nephrhytis</i> spp.
Castor Bean	<i>Ricinus communis</i>	Arrowhead plant	
Cherry	<i>Prunus</i> spp.	Oak (acorns)	<i>Quercus</i> spp.
Cherry-laurel	<i>Prunus laurocerasus</i>	Oleander	<i>Nerium oleander</i>
Chinaberry	<i>Melia azedarach</i>	Peony	<i>Paeonia</i> spp.
Christmas rose	<i>Helleborus niger</i>	Pepper, Christmas	<i>Solanum pseuodcapsicum</i>
Crown of Thorns	<i>Euphorbia milii</i> (E. splendens)	Pepper, Ornamental	<i>Capsicum annum</i>
Daffodil	<i>Narcissus pseudo-narcissus</i>	Philodendron	<i>Philodendron</i> spp.
Daphne	<i>Daphne</i>	Poison Hemlock	<i>Conium maculatum</i>
Deadly Nightshade	<i>Solanum dulcamara,</i>	Poison Ivy	<i>Toxicodendron radicans</i>
	<i>Atropa belladonna</i>	Poison Oak	<i>Toxicodendron quereifolium</i>
	<i>Dieffenbachia</i> spp.	Poison Sumac	<i>Toxicodendron vernix</i>
		Pokeweed	<i>Phytolacca americana</i>
Dieffenbachia,		Potato "eye,"	<i>Solanum tuberosum</i>
Dumbcane	<i>Colocasia</i> spp.	green spots, leaves	
Elephant Ears	<i>Hedera helix</i>	Pothos	<i>Scindapsus aureus</i>
English Ivy	<i>Euonymus</i> spp.	Privet	<i>Ligustrum</i> spp.
Euonymous	<i>Mirabilis jalapa</i>	Rhododendron	<i>Rhododendron</i> spp.
Four O' Clocks	<i>Digitalis purpurea</i>	Tomato plant leaves	<i>Lycopersicon esulentum</i>
Foxglove	<i>Prunus</i> spp.	Virginia Creeper,	<i>Parthenocissus quinquefolia</i>
Fruit pits or seeds	<i>Gladiolas</i> spp.	American Ivy	
Gladiolas	<i>Ilex</i> spp.	Water Hemlock	<i>Cicuta maculata</i>
Holly	<i>Hyacinthus orientalis</i>	Wisteria	<i>Wisteria</i> spp.
Hyacinth	<i>Hydrangea</i> spp.	Yew	<i>Taxus</i> spp.
Hydrangea	<i>Iris</i> spp.		
Iris, flag			

A Word About Poisonous Plants

Plants are the most frequently ingested agents reported to poison centers for children under one year of age and they rank third for all age groups. Fortunately, many of these incidents are not major poisonings and require little or no treatment.

For poison centers, plant poisonings present several problems. Unfortunately, much of the literature on poisonous plants is outdated and poorly documented. While numerous books and articles report the "deaths" caused by the poinsettia plant (*Euphorbia pulcherrima*), all of these apparently refer to only one death (a child in Hawaii in 1919). This case is so poorly documented as to make it questionable. Recent research suggests that large amounts of the poinsettia must be eaten before even minor symptoms (nausea, vomiting) are seen. Confusion over common names poses another problem. Snakeberry is a common name for the poisonous *actaea* plant with its distinctive "doll's eye" white berries. In Maryland, however, snakeberry frequently refers to the non-toxic wild strawberries that "snake" across the lawns.

The nature of plants themselves often causes the most problems. Questions such as — Why are some plants edible after being properly cooked and poisonous when eaten raw? Why are the fleshy parts of tomatoes, potatoes, cherries, apples, apricots, etc., safe to eat when the seeds, pits, "eyes" and green spots can cause poisoning? How much toxin is present in a given plant or part of a plant? — have no easy answers. So each situation must be evaluated individually.

This list is intended to make you aware of the many plants that are suspected of being poisonous. While it does not mention every poisonous plant, it lists those plants about which the Maryland Poison Center is most frequently called.

Jacquie Lucy, *Editor*

FIRST AID for PLANT EXPOSURES

SWALLOWED — (1) Remove any remaining plant material from mouth.

(2) Rinse mouth with water.

(3) If signs of burns or irritations, give milk.

(4) Bring plant and patient to phone if possible.

(5) Call the Maryland Poison Center immediately.

EYE CONTAMINATION — (1) Flush eye with water immediately for at least fifteen minutes (hold head under the faucet as if washing hair.) DO NOT USE AN EYE CUP.

(2) Call MPC as soon as eye is thoroughly rinsed.

SKIN CONTAMINATION — (1) Rinse skin well with soapy water.

(2) DO NOT apply any cream, lotion, ointment, etc.

(3) Call MPC as soon as possible.

For A Limited Time

The MPhA's Blue Cross and Blue Shield Major Medical Health Insurance Plan is currently in a limited enrollment time period. Coverage is offered for members, their family and their non-pharmacist employees.

**Take advantage of this
Association membership benefit.**

Compare rates and coverage with your current health insurance plan. You'll discover why so many pharmacists have already enrolled.

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**Blue Cross
Blue Shield**

Moskowitz is President of ASCP

Milton S. Moskowitz of Silver Spring, Maryland was installed as 1981 President of American Society of Consultant Pharmacists at ceremonies held in Chicago, Illinois during the Society's 11th Annual Meeting. Mr. Moskowitz was elected in October, 1979 by the ASCP membership and served as President-Elect of the Society during the past year. He is President of Accredited Surgical Sales Company of Maryland, Inc., a pharmacy and surgical supply business which provides pharmaceutical and consulting services to 22 nursing homes and 3,000 long term care patients.

Other officers installed by Immediate Past President Mark Abrams were President-elect Jerry Fine of Baltimore, Maryland and Vice President Denis Portaro of Studio City, California. Mr. Fine is a full-time consultant pharmacist for MSC, a national multi-facility nursing home organization. Mr. Portaro supervises and operates one of the largest long term care pharmacy practices in the country — Niemerow Pharmacies, Inc.

ASCP is the national professional society of pharmacists who specialize in providing services to meet the unique needs of the nation's institutionalized elderly. The Society was founded in 1969 to promote and improve consultant pharmacist services through education, the development of professional standards, and the provision of services to its members. For further information write to ASCP at 2300 Ninth Street South, Suite 503, Arlington, VA 22204.

AACP to Meet Here in 1984

The American Association of Colleges of Pharmacy has announced that its 1984 Annual Meeting will be held July 19-23 in Baltimore. The announcement coincides with the groundbreaking for an \$11 million building for the School of Pharmacy of the University of Maryland Baltimore. The School is the nation's third oldest pharmacy college and has long been a leader in pharmaceutical education. Maryland Pharmacy Dean William J. Kinnard, Jr., Ph.D. is a former President of the Association and Professor Ralph Shangraw, Ph.D. is presently a member of its Board of Directors.

The American Association of Colleges of Pharmacy is the academic society of the nation's 72 accredited colleges of pharmacy. Founded in 1900, AACP provides a national forum for the discussion and resolution of issues in pharmaceutical education. Its annual meeting attracts over 600 professors and deans from the United States and Canada. Registrants and their families will account for an anticipated 1,000 visitors to Baltimore for the 1984 meeting.

In announcing the meeting, the Association's Executive Director, Dr. Christopher A. Rodowskas, Jr., observed "that as a native Baltimorean, I am awestruck by the miraculous transformation of the downtown area. Perhaps, even more remarkable is that the renewal of the city has not harmed but has enhanced the rich and varied cultural character of the city that has always been its unique source of charm and grace."



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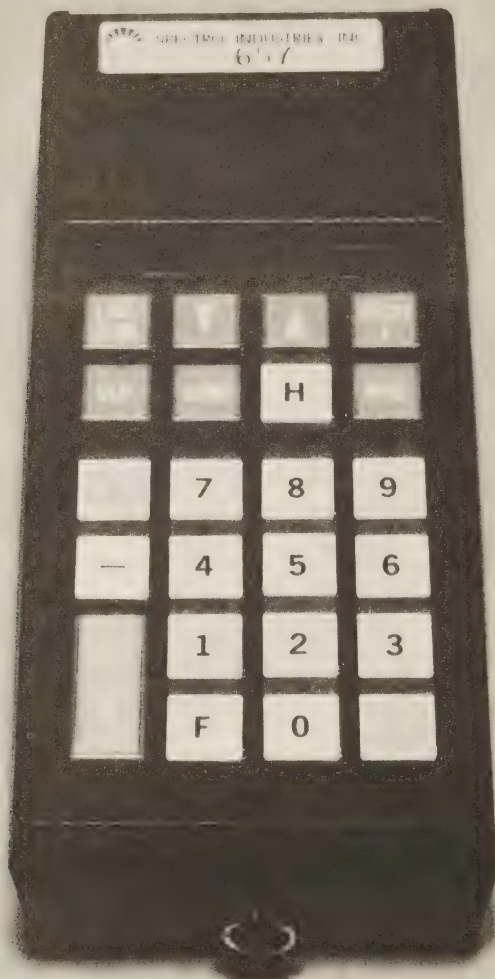
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- Notification for the patient under the Drug Product Selection Law.
- Heart Shaped Stickers — no charge
- Information on the Blue Cross/Blue Shield Major Medical Health Insurance Program
- The Association's Employment Clearinghouse, helping pharmacists and employers find one another
- I.C. collection help
- Information on the NEW USP/NF on sale from MPhA.

For these and many other services, contact Sharon at the MPhA Office. (301) 727-0746.

ASHP 1981 Meeting Plans

Two National Institute programs, a redesigned Annual Meeting and House of Delegates session and the 16th Annual Midyear Clinical Meeting will make up the 1981 continuing education meeting schedule of the American Society of Hospital Pharmacists (ASHP).

The first National Institute, from March 8-14, in Atlanta, will feature six separate programs on clinical pharmacokinetics, hospital pharmacy facility design, planning, packaging and selling a new hospital pharmacy service, oncology pharmacy practice, drug use review and quality assurance and the management of hospital pharmacy services. (See New Release No. 72 for complete details.)

A second National Institute is planned for August 16-22 in Portland, OR, with details on programming to be announced at a later date.

Also scheduled as part of ASHP's 1981 C.E. meeting programming is the 38th Annual Meeting and House of Delegates session, June 7-11, in Chicago. In addition to a wide variety of educational programs planned for this Annual Meeting, a full-scale industry exhibit program will be introduced.

Finally, the 16th Annual ASHP Midyear Clinical Meeting will be held December 6-10, 1981, in New Orleans. The meeting will be headquartered at the Rivergate.

For more information, contact ASHP, 4630 Montgomery Ave., Washington, D.C. 20014.

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SITUATION WANTED

Student graduating in class of 1981 seeks employment. Three years pharmacy experience. Educational background in Geriatrics, Community Management, and Computers. Resume and references on request to Box 4, Maryland Pharmaceutical Association Office.

M. Eugene Streett of Boyd and Fulford Drugs in Bel Air, Maryland, and Thomas R. Hoopes of Frederick Memorial Hospital in Frederick, Maryland, have each won \$750 award in the Burroughs Wellcome Pharmacy Education Program. The money will be presented to a school of pharmacy as a scholarship for students.

3 P.M., Inc. announces that it will be assuming responsibility for pharmacies that utilize the Shared Pharmacy Computer System. Shared Pharmacy Systems are installed in approximately 100 pharmacies in six states including Maryland.

Numbers to call for the Tel-Med program in Maryland are:

Provident Hospital — 728-2900
University of Maryland Hospital — 528-3111
Prince George's County — 345-4080
Sacred Heart Hospital, Cumberland — 777-8383

Your help is needed by the Centennial Committee. Send a short note to identify any pharmacy family or related group that has had pharmacists since 1882. Identify a person by name, address and telephone number so that the Centennial Committee may arrange to specially recognize them during 1982.

WARNING

**Any person obtaining
a controlled substance
by use of a forged and/or
stolen prescription is in
violation of federal law
and upon conviction may
be fined up to \$30,000
and/or imprisoned for
up to 4 years.**

THE MARYLAND PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

FEBRUARY, 1981
VOL. 57
NO. 2



Salary and Employment Conditions Survey

The New FDA Drug Equivalence List

Jurisprudence Self-Test

The Great Debate . . . **9:15-10:00 a.m.**

"P.D. or not P.D. That is the Question"

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FEBRUARY, 1981

VOL 57

NO. 2

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Well, as one frog said to the other, "Time's sure fun when you're having flies." It is true that I am now past the mid-point of my presidency in the Association and I would now like to take this opportunity to reflect on a serious situation that I see developing in pharmacy.

I am talking about breaking the rules. Life in pharmacy is a lot more tense now that inspectors, auditors, detectives, agents and undercover buyers have become a part of the scenery. The point is, however, that none of us can condone breaking the rules. And, this also applies to third party plans; much as we may find their rules and regulations distasteful.

We all need to abide by the rules and agreements of these third parties if we want to participate with them. It seems to me that there are only two options open to us: Abide by the agreements we have (while working to improve them) or not participate with the third party in question. I believe that it is tragic that the third parties have placed some pharmacists into a position where they feel the only way they can survive is by cutting corners. Surely, this situation must be changed. Getting caught cutting corners leads to newspaper headlines which becomes one more black eye for pharmacy. If you can not live by the agreements of a third party program, then it is time to reassess your continued participation in that program.

I would like to urge all of you to participate in some fashion in National Poison prevention Week — March 15-21, 1981. See page 28 for additional details.

I also look forward to seeing many of you at the 1981 Spring Regional Meeting, March 12, 1981, at the International Hotel at the Baltimore-Washington International Airport starting at 8:00 p.m. We are looking for a great crowd to hear the pros and cons on the use of the professional designation "P.D." with the title "Doctor of Pharmacy" to replace the traditional R.Ph.

Samuel Lickter

\$Salary and Employment Conditions Survey

This survey was prepared under the direction of the Maryland Pharmaceutical Association by three senior student externs on a one month rotation through the association office. Ellen Lyons Perez helped design the survey and distributed it to the membership. Leslie Goldstein recorded the results and began the statistical analysis. Michael D. Ball completed the statistical analysis, tabulated the results, and wrote the narrative.

Employment Conditions Survey

In November of 1980 the Maryland Pharmaceutical Association mailed a survey to its membership to assess the employment conditions that prevail in the state of Maryland, with a response rate of 18.9%. Table I breaks down the respondents demographically.

Tables II through IV contain general salary information. The average salary for a pharmacist in Maryland is \$24,376. This wage is higher than the national average; there were no unemployed respondents. Males made slightly more than females, but this is probably a statistical error due to the low number of female respondents rather than actual discrimination. Not surprisingly, the average salary for pharmacists starts at a comfortable level, but plateaus after five to ten years with minimal increases in later years. Geographically, the best salary was in the Suburban/Washington, D.C. area. Pharmacists there had almost a thousand dollar salary advantage over the average Maryland pharmacist. The Baltimore city and county areas were below average in salary, while its southern neighbor, Anne Arundel County, was six hundred dollars above the state average. Pharmacists working part-time, 17.7% of the respondents, were split two to one, male to female; and had an average hourly salary of ten dollars.

In an attempt to further define salary parameters, I have broken down the figures for Baltimore city/county area into job classifications, average salaries, and the percent response for all Baltimore area respondents in table V. Baltimore city/county was used due to its large sample size and diversity. Keep in mind the average salary for this geographic area is low at \$23,699. The highest paid group is the chain staff pharmacists, followed closely by pharmacy managers. It is interesting to note that pharmacy owners are not paid significantly more than hospital pharmacists. The lowest paid group was the Independent staff pharmacists with a salary that correlated with the average salary for a beginning pharmacist, (21-25 yr. age bracket).

Table I
Respondants

Pharmacy Owners.....	24.1%	(42)
Community Store Managers.....	17.2%	(30)
Hospital Pharmacists.....	12.6%	(22)
Staff Chain Pharmacists.....	18.9%	(33)
Staff Independent Pharmacists.....	20.1%	(35)
Female Respondants.....	24.7%	
Male Respondants.....	75.2%	

Fringe benefits make up a significant portion of every employment package. Our survey indicates an increased variety and number of benefits per respondent compared to a similar 1978 M.Ph.A. survey. Commonly offered benefits are liability (71.1%), life (60.2%), disability (60.1%), health (85.7%) Insurance. In addition, sick pay (80.6%), paid holidays (90.5%, ave: 6.5/yr.) and a personal purchase discount (84.2%) were also offered. Benefits occasionally offered are pension plans (45.6%), prescription plans (49%), and a bonus plan (50.4%). Uncommon benefits, but not unheard of, are profit sharing plans (27.3%) and a paid uninterrupted lunch (27.8%). 59.9% of employers provided jackets to their employees, but only 13.6% offered to have them laundered. Continuing education is paid for by 38.5% of the pharmacist's employers. Payment of state, local or national pharmacy association dues is not a common benefit.

Table II
Average Salary by Age

Age	Avg. Salary	# Respondants	% Respondants
21-25	21,000	23	13.2%
26-30	24,212	37	21.2%
31-35	26,000	21	12.0%
36-40	27,800	11	6.3%
41-45	24,583	12	6.8%
46-50	26,375	16	9.1%
51-55	25,636	24	13.7%
56-60	20,200	11	6.3%
61-65	24,375	11	6.3%
66-70	26,000	8	4.5%



Table III

Average Salary per geographic Practice Setting

Average salary for the State of Maryland	\$24,376
Statewide male salary	\$24,621
Statewide female salary	\$23,857

Anne Arundel County	\$25,000
Baltimore City/county	\$23,699
Montgomery County	\$25,125
Prince Georges County	\$26,071
*Washington, D.C.	\$25,250

*Not Included in State Average Salary

Table IV

Part-time Employment

Average part-time hourly wage	\$10.00
Total part-time respondents	17.7% (31)
Female	6.3% (11)
Male	11.4% (20)

Table V

Average Salary by Occupation in Baltimore city/county area

	Avg. Salary	Respondants
Pharmacy Owners	\$23,975	28.8%
Pharmacy Managers	\$25,313	15.0%
Hospital Pharmacists	\$23,000	21.2%
Staff Chain Pharmacists	\$26,259	11.2%
Staff Independent Pharmacists	\$21,318	23.8%

Polled on the subject of patient profiles, 88% of the total respondents thought that patient profiles are useful pharmacy practice tools; however only 57.2% of this group used profiles.

The heart of any employment condition is satisfaction with the various facets of the occupation. Tables VI and VII delineate this information. Respondants rating their "general working conditions," "physical working conditions", "Employee/supervisor relationships" and "employer/employee relationships", responded good or excellent 80% of the time. Only 3.2% of all respondents thought their general working conditions were poor, and under 2% perceived a poor relationship with their employers or supervisors. When comparing their present job to their idea of "the perfect job", 30.2% responded "very close", 47.5% "adequately close." 11.2% answered their job is not satisfactory. In fact 14.3% of the respondents indicated that they were leaving their present position due to dissatisfaction. The

most dissatisfied group is the 21 to 30 year age group; 66% of all dissatisfied respondents were in that age bracket. Many pharmacists (84.2%) said that there existed a mechanism for the resolution of complaints, yet only 25.3% had a formal system for problem-solving.

Table VI

Attitudes toward working conditions

Response:	Excellent	Good	Fair	Poor
General working Conditions	31.0%	50.6%	15.2%	3.2%
Physical Working Conditions	35.8%	45.9%	16.4%	1.9%
Employee/Supervisor Relationship	43.4%	42.8%	12.4%	1.4%
Employee/Employer Relationship	44.8%	41.4%	13.1%	.7%

Table VII

How close is this job to your idea of the "Perfect" job?

Age Group	%Answering Very Close	%Answering Adequate	%Answering Not Satisfactory
21-30	7.4%	15.5%	7.4%
31-40	7.4%	9.7%	1.1%
41-50	6.3%	9.7%	.5%
51-60	5.7%	8.6%	1.1%
61-70	3.4%	4.0%	1.1%
	30.2%	47.5%	11.2%

Total % Respondents

Of all pharmacists who were dissatisfied with their jobs, 66% were in the 21 to 30 yr. age group.

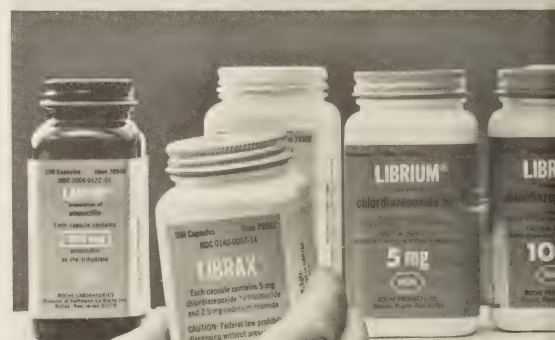
Editorial Comment —

— Mike Ball

After analyzing the survey, several salient points come to mind. Pharmacists do not have a salary structure that realistically approaches their level of service or experience. The average Maryland pharmacist's salary at \$24,376, with a 44 hour week, translates into \$10.65 per hour. Compare that to the salary of any trade union worker, then compare the inherent responsibility and liability of the pharmacist. In addition, the salary plateau reached by pharmacists after five to ten years of practice is discouraging, especially to those just entering the profession. The low rate of remuneration for the pharmacy owner puts a damper on those thinking of owning independent community pharmacies. Finally I'm not surprised to find more dissatisfied pharmacists in the twenty-one to thirty year age group. The wide gap between the reality of practice and how one is taught in school to practice is disheartening.

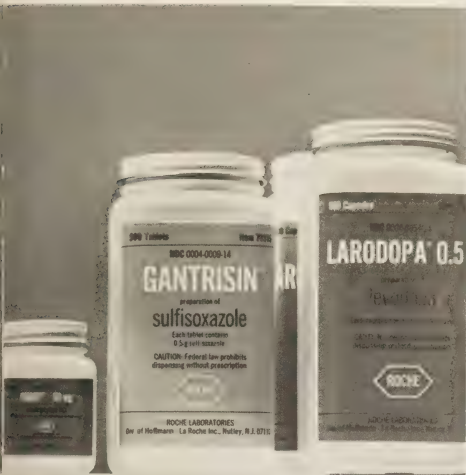
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Everything about Roche, from product research and manufacturing procedures to the representative who services your pharmacy, can be characterized by a single word—quality. Each time you dispense one of our products, you dispense the quality that lies behind the health care profession's wide acceptance of Roche. In fact, in a recent survey, Roche was the only company to achieve an "excellent" rating by pharmacy managers in all these significant areas: product quality, service effectiveness, and sales representation.¹



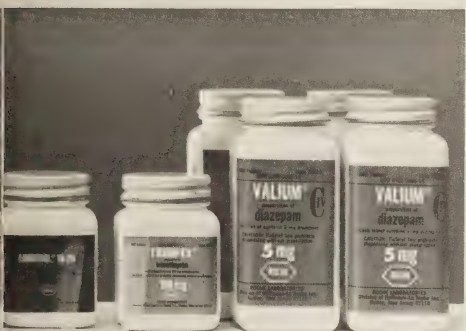
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References:

1. Chain Drug Review, 1(23):6, July 30, 1979
2. Report prepared by Pracon Inc., Fairfax VA
3. Data on file, Hoffmann-La Roche Inc., Nutley NJ
4. Pharmacy Times, Inc., 1979 Report

Roche Rx's build traffic and traffic builds business



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

A Century of American Pharmacy

by
David L. Cowen



continued from January

This series of articles has been contributed by the American Institute of the History of Pharmacy in commemoration of the centennial of the Maryland Pharmaceutical Association. While the centennial is still a year away, the Centennial Celebration Committee is working now to acquaint pharmacists with their professional heritage.

The Education of the Pharmacist

It was of course inevitable that along with the restriction of the practice of pharmacy to trained practitioners, the quality of that training also be improved. Apprenticeship had been the time-honored process of pharmaceutical education and the first American statutes usually gave credit toward the apprenticeship requirements for the time spent in a college of pharmacy. This began to change early in the twentieth century and "prerequisite laws," that is laws requiring graduation from a college of pharmacy before an applicant could be eligible for examination, appeared on the statute books. The late Elmer Holmes Bobst, pharmaceutical industrialist of renown, tells the story of the start of his upward climb; country boy from Lititz working in Philadelphia pharmacies, studying on his own, and rushing to take the examination first for assistant and then for registered pharmacist late in 1905, just in time to beat out the Pennsylvania "prerequisite law" that took effect on January 1, 1906. In other states such laws took effect much later, in 1920 in Maryland and New Jersey and in 1922 in North Carolina, for example.

As a concomitant of the organization of pharmacy on the state level and the establishment of examination and registration requirements, the American colleges of pharmacy began to proliferate. Following the example of the Philadelphia College of Pharmacy (1821), the College of Pharmacy of the City of New York (1829) and the Maryland College of Pharmacy (1840), eight more colleges had been established before 1870. By 1898 no fewer than 48 more colleges of pharmacy had been established. Some of these did not last very long, but 32 of the colleges of pharmacy now in existence had origins in the 19th century. Most of the colleges were proprietary institutions, but with a very few exceptions they have become affiliated with Universities, just as the Maryland College of Pharmacy became the Department of Pharmacy of the University of Maryland in 1904 and the

School of Pharmacy of the University of Maryland in 1920. This, plus the fact that 14 state universities established departments or schools of pharmacy in the 19th century, has placed pharmacy on the university level of education in the United States.

The curriculum of the early colleges of pharmacy was scant; lectures in materia medica, botany, chemistry, and practical pharmacy, with a few demonstrations was its extent. The part time, evening program (in 1868 the Philadelphia College of Pharmacy held its lectures on Monday, Wednesday, and Friday evenings) usually took two years and culminated in the certificate of graduation that eventually became known as the Ph.G. degree.

Under the influence of university standards of education, under the impact of the late nineteenth century developments in the sciences, especially organic chemistry, bacteriology, and pharmacology, and under the pressure from new national organizations like the National Association of Boards of pharmacy, the American Association of Colleges of Pharmacy, and the American Council of Pharmaceutical Education, the standards of pharmaceutical education improved. Fulltime, day programs, with required laboratory instruction became common. By 1907 a two-year curriculum had been adopted; by 1925 a three year program; by 1932, a four-year program leading to the bachelor's degree; and by 1960 a five-year program. Most important was the changing direction of the curriculum; increasingly pharmacology was becoming the bulwark of the curriculum. As Dean Linwood F. Tice of the Philadelphia College saw the development, the pharmacist had to be trained to master therapeutic incompatibilities, understand adverse drug reactions, involve himself in the control of drug use, be able to evaluate the best drug for a given purpose, and be competent to counsel other health professionals on medication or laymen on non-prescription medication. By the early 1970's the shift in the character of pharmaceutical education in the direction to which Dr. Tice had been pointing was evident; "clinical pharmacy" programs were generally available.

The rapidity of the innovations in science and technology in the twentieth century and the changing role of the pharmacist have brought a new dimension to pharmaceutical educa-

tion: continuing education for the practicing pharmacist. Extension services for pharmacists can be traced back to the 1890's, but it was not until the 1930's that pharmacy colleges in general under the stimulation of Robert P. Fischelis, evinced an interest in continuing education. In 1950 the University of Wisconsin and Rutgers University instituted what have been called "the first modern pharmaceutical extension services." This has culminated in a number of states (beginning with Florida and Kansas in 1967) in the establishment of regulations that impose a minimum of continuing education as a condition of renewal of the pharmacist's license.

The Pharmaceutical Sciences

One need only follow the changes in the curriculum of American colleges of pharmacy to recognize the transformation that has taken place in the last 100 years. The introduction of courses in physics, physiology, advanced chemistry, microbiology, not to mention advances in pharmacology; the need to master new techniques of instrumentation and metrology; the ability to use and understand electronics and the computer; and the venturing into radioactive pharmaceuticals, have transformed the pharmacist into a man of science. The *materia pharmaceutica*, now so much the product of the huge and costly research laboratories of industry, are so complex as to require a high degree of scientific understanding, and so potent as to make such understanding a matter of social responsibility on the part of the pharmacist. It is but a

generation since the therapeutic revolution began that gave us the vast array of chemotherapeutic agents like the sulfas, penicillin, and streptomycin, and the chemical agents like hormones, vitamins, antihistamines, antihypertensives, diuretics, cardiac drugs, and tranquilizers.

The Metamorphosis of pharmacy from an art into a science is also pointed out by the changes that took place in the United States Pharmacopoeia. The sixth revision (1882) of that work — the first to be issued under a Committee of Revision on which the majority were pharmacist — indicated the kind of change that was taking place. As Glenn Sonnedecker has described it:

Casual mention of a few tests (in the former revisions) was replaced with detailed tests for identifying and determining the purity of many of the drugs. Detailed processes for assaying the alkaloids appeared for the first time. Drugs from vegetables and mineral kingdoms were more meaningfully described as to physical characteristics and, where possible, chemical properties. Symbolic formulas and molecular weights were introduced. . . . Nomenclature was revised.

Compare this with Dr. Sonnedecker's comment on the USP XIX (1975): "For the first time test procedures included high-pressure liquid chromatography, X-ray diffraction spectrophotometry, and atomic absorption spectrophotometry, as well as far more frequent use of gas-liquid and thin-layer chromatography."

to be continued



This 47th Annual Convention of the MPhA was held in 1929.

Handle Error With Care

by
Estelle G. Cohen
Consumer Member
of the Board of Pharmacy

Take this recent conversation between a pharmacist and a consumer in a Maryland Pharmacy:

Lady to pharmacist:

"Sir, this prescription is written for 200 mg. of _____, and you have given me 500 mg. of _____".

Pharmacist:

"Listen Lady, I have been a pharmacist for 30 years and I have made mistakes far greater than that . . . You ought to be glad that's all that happened".

As one might expect, the pharmacist's retort sat poorly with the consumer. Consequently, the angered consumer lodged an official complaint with the Board of Pharmacy. Though the matter was eventually settled, a record of the incident was made in the pharmacist's name for any necessary future reference. How unnecessary this scenario was! Had the pharmacist acknowledged and corrected his error and apologized, the matter would have gone no further.

Do you realize that the majority of the complaints we receive at the Board of Pharmacy reflect communication problems between pharmacists and patients? For example, for consumers it is uncomfortable to ask a question of a pharmacist when he is separated by a counter as well as the space behind the counter and a semi-partition behind the space behind the counter and makes no effort to come out front. First of all consumers must raise their voices to be heard, and not everybody wants their drug problems known. Then when the pharmacist keeps typing and doesn't look up during the conversation (as if we are not quite worth their time), we feel slighted . . . but then when they top it all off with a dispensing or labeling error, we get angry.

Scientists though you may be, your craft is less than perfect if you fail to follow through on each drug related transaction with the proper professional attitude and style.

It behooves the pharmacist to recognize that people who purchase drugs are often ill or preoccupied with worry for themselves or someone for whom they care. And so, if the person is testy, don't join him and become surly — rise above him, help him, try to address his concerns in a compassionate manner, (but not in a patronizing manner). Above all, if you have made a mistake be womanly or manly about it — handle errors with care.

The Shering Report issued in 1979, notes that consumers feel that the most important factor in dealing with a pharmacy is that the prescription is filled promptly, and not such pertinent factors as confidence in the pharmacist, or information on the label, or the availability of the pharmacist for consultation. This should tell you that the public has lost its information pertaining to their health to them. Don't compound this situation by being defensive or hostile when you communicate. Be considerate, be professional.

TYLENOL[®] with Codeine

tablets \oslash /elixir \oslash



mild to
moderate pain

moderate to
severe pain

Summary of Prescribing Information

Description

Tablets: Contain codeine phosphate*: No. 1—7.5 mg. (1/4 gr.); No. 2—15 mg. (1/2 gr.); No. 3—30 mg. (1/2 gr.); No. 4—60 mg. (1 gr.)—plus acetaminophen 300 mg.

Elixir: Each 5 ml. contains 12 mg. codeine phosphate* plus 120 mg. acetaminophen (alcohol 7%).

*Warning: May be habit forming.

Actions: Acetaminophen is an analgesic and antipyretic; codeine an analgesic and antitussive.

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: *Drug dependence:* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients: Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.

Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.

Pediatric use: Safe dosage of this combination has not been established in children below the age of three.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.

Dosage and Administration: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. **TYLENOL with Codeine** tablets are given orally. The usual adult dose is: Tablets No. 1, No. 2, and No. 3 One or two tablets every four hours as required. Tablets No. 4 One tablet every four hours as required. **TYLENOL with Codeine** elixir is given orally. The usual doses are **Children (3 to 6 years):** 1 teaspoonful (5 ml.) 3 or 4 times daily. **(7 to 12 years):** 2 teaspoonful (10 ml.) 3 or 4 times daily. **(under 3 years):** safe dosage has not been established. **Adults:** 1 teaspoonful (5 ml.) every 4 hours as needed.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For information on symptoms/treatment of overdosage, see full prescribing information.

Full directions for use should be read before administering or prescribing.

TYLENOL with Codeine tablets are manufactured by McNeil Laboratories Co., Dorado, Puerto Rico 00646.

Caution: Federal law prohibits dispensing without prescription.

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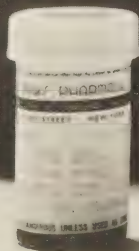
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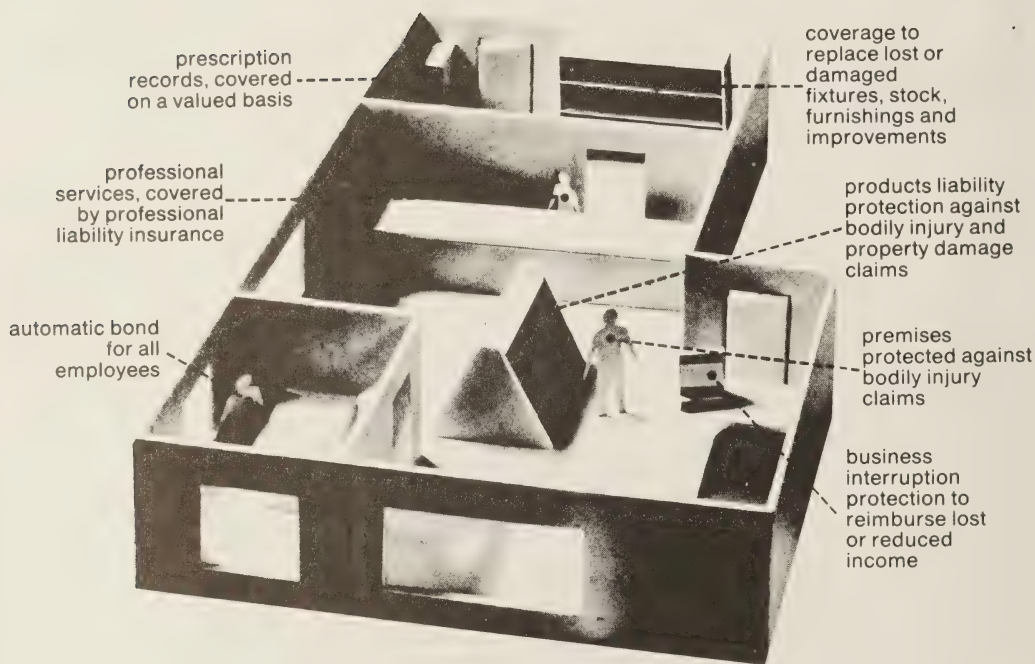
†BASED on new and refill prescriptions, 1st Quarter 1980

*Independent Market Research Study-263 stores, June 1980

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Perspectives in Pharmacy

Professional Drug Product Selection

Presented
in the interest
of better
informed pharmacy

John C. Wilkie, Jr., R.Ph.
Executive Secretary
Board of Pharmaceutical
Examiners of South
Carolina

"One of the major problems facing pharmacists throughout the country today is the availability of products which have not been approved by FDA. There are drugs on the market with approved New Drug Applications (NDA's) and Abbreviated New Drug Applications (ANDA's). Another group of drugs that was marketed between 1938 and 1962 has been approved for safety but not for efficacy. This group is being reviewed under the Drug Efficacy Study Implementation (DESI) process. A fourth group of drugs marketed prior to 1938 is not subject to premarketing clearance procedures, yet products in this category are marketed every day.



John C. Wilkie, Jr., R.Ph.

"Look at the possibility of the pharmacist's liability in dispensing drugs without FDA's approval—the drugs may be improperly formulated, may have formulations causing varied bioavailabilities, may be labeled incorrectly, may cause therapeutic problems, may have adverse reactions, and on and on. In addition, such drugs may be on the market with patent infringements, thus placing the pharmacist in another barrel of

hot water.

"Pharmacists need help — consumers need to rest assured that they are receiving approved drugs, and the medical and pharmacy professions need assurance that all drugs on the market are approved or exempted. Mean-

while, you must know your manufacturer or distributor and, even then, make sure the firm is reliable and responsible."

Lawrence H. Block,
R.Ph., Ph.D.
Professor of
Pharmaceutics
Duquesne University
School of Pharmacy

"The scientific aspects of drug product selection have become mired in controversy resulting from the economic or political casting of the issues involved. Product selection by the pharmacist, when permitted by law, ought to result from a consideration of drug product bioequivalence data, the active ingredient, the dosage form, and the drug product manufacturer. However, accurate evaluations of drug product bioequivalence data and the risk of bioequivalence incurred with specific active ingredients

or dosage forms are difficult. Moreover, the FDA's publication of the therapeutically equivalent products list is only an initial step in an effort to document individual product acceptability. The scope of the FDA list is limited; drugs marketed prior to 1938 are not included in the listing. Although these drugs (e.g., methenamine, nitroglycerin, phenobarbital, and thyroid) represent only about 25 percent of the drugs dispensed in the United States, they represent a substantial portion of the drugs available from multiple sources. In addition, the FDA list doesn't reflect manufacturer performance on a batch-to-batch basis. The pharmacist must consider the product manufacturer's potential for replicating a product from batch to batch. A tally of 590 manufacturers involved in approximately 3300 drug product citations in the FDA's weekly reports between 1970 and 1978 refutes the contention that

all pharmaceutical manufacturers maintain equally effective quality-control programs."

Kenneth G. Mehrle, R.Ph.
Past President, National
Association of Retail
Druggists

"The feds and the states want to use drug product selection to cut drug costs—and nothing more—without assuming any liability risks. In state legislature after state legislature, drug product selection proposals



Lawrence H. Block, R.Ph., Ph.D.



Kenneth G. Mehrle, R.Ph.

have pitted manufacturers against pharmacy groups, pharmacy groups against consumer organizations, and organized medicine against both pharmacy and consumer groups. Everyone has ended up fighting everyone else. What no one is mentioning is the professional aspect of DPS. That has been irretrievably lost—at least for now.

"In my opinion, true drug product selection is possible only if four conditions exist: (1) The drug industry is reconciled to the idea; (2) the medical profession does not see it as an affront; (3) the FDA stands by every potentially substitutable product and is willing to assume all resulting liabilities; and (4) the pharmacist's professional judgment—and not dollar and cents accountability and the fear of fines and imprisonment—should be the deciding factor in whatever product is dispensed."

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46285

The views herein are presented as a service to pharmacists and may or may not represent the views of Eli Lilly and Company.

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The New FDA Drug Equivalence List

A Continuing Industry Relations Committee Project

We understand that each Maryland Pharmacy will shortly be receiving a copy of the new FDA drug list described below which will be used as the State's Positive Formulary. The following information is presented so that Maryland Pharmacists will be able to effectively use the list in drug product selection.

The long awaited Food and Drug Administration listing of Approved Prescription Drug Products with Therapeutic Equivalence Evaluations was published in the Fall of 1980 and despite inherent shortcomings such as the time lag between approvals and publications, the book contains a wealth of information which can prove a valuable adjunct for the pharmacist in using his knowledge to provide the least expensive quality product for the patient.

The book cost \$20.00 and can be purchased from the U.S. Government Printing Office, Washington, D.C. 20402, including a year's supplements.

The format includes a listing of all Drug Products which have been approved for marketing on the basis of safety and efficacy, with a coded guide to note those which FDA considers therapeutic equivalents when the product is multisource. Equally important are the pages of explanation showing FDA's reasoning for considering products equivalent or inequivalent both by classes and in some cases by specific example. Pre 1938 drugs, which do not require pre-marketing approval by FDA are not covered, nor are those drugs marketed between 1938 and 1962 which are still being studied under the Drug Efficacy Study Implementation (DESI) program. Drugs in the latter category are listed in a separate appendix.

The Maryland State Formulary Committee, charged with developing a list of interchangeable products for pharmacists to use in product selection will utilize this book as a starting point for an expanded list of products which you can use in selecting brands. However, to fully understand the reasons that drugs are or are not interchangeable it is advisable to read Approved Prescription Drug Products explanation sections. Also by having the complete lists you will be able to identify those drugs which are not legally interchangeable but which do have a NDA or an ANDA and which you might feel confident in interchanging after consultation with the physician.

Multisource drugs are identified with a two letter code, the first telling whether the product is considered interchangeable ("A") or not ("B") and the second designating a more specific reasons for placing the drug in either "A" or "B".

DRUGS WHICH ARE CODED "A" ARE CONSIDERED TO BE THERAPEUTICALLY EQUIVALENT TO OTHER PHARMACEUTICALLY EQUIVALENT PRODUCTS.

Drug products designed with an "A" code fall under one of two main policies: 1. for those active ingredients for which no bioequivalence issue is known or suspected, the therapeutic equivalence of pharmaceutically equivalent products is presumed, so long as the products are manufactured in accordance with Current Good Manufacturing Practice regulations and meet the other requirements of their approved applications; 2. for those drug products containing active ingredients which have been identified by FDA as having actual or potential bioequivalence problems (21 CFR 320.22 or 42 FR 1648, January 7, 1977). An evaluation of therapeutic equivalence is assigned to pharmaceutical equivalents only if the approved New Drug Application contains adequate scientific evidence supporting the bio-equivalence of the product to a selected standard product. This evidence may be an *in vivo* equivalence of the product to a selected standard product. This evidence may be an *in vivo* bioavailability study or an *in vitro* dissolution rate study or both, depending upon the drug.

There are some general principles which may affect the substitution of pharmaceutically equivalent products in some specific cases. Prescribers and dispensers of drugs should be alert to these principles so as to deal appropriately with situations which require professional judgement and discretion.

1. There may be labeling difference among pharmaceutically equivalent products which require attention on the part of the health professional. For example, pharmaceutically equivalent powders to be reconstituted for administration as oral or injectable liquids may vary with respect to their expiration time or storage conditions after reconstitution. An FDA evaluation that such products are therapeutically equivalent is applicable only when such products are reconstituted, stored, and used under the conditions specified in the labeling of each product.
2. Occasionally there may be variations among pharmaceutically equivalent products in the labeling instructions on dose and administration. For example, a particular brand of an antibiotic might require administration on an empty stomach, while another brand might permit administration without regard to food intake on the basis of blood level studies done after administration in the presence of food. An FDA evaluation of therapeutic equivalence in such cases is applicable only when such products are taken in accordance with labeling directions for the particular product.

3. In some cases closely related products are listed as containing the same active ingredients but in somewhat differing amounts. In determining which of these products are pharmaceutically equivalent, the agency has employed a criterion that products with labeled strengths of an ingredient that do not vary by more than 1% will be considered pharmaceutically equivalent.

4. Different salts and esters of the same therapeutic moiety are regarded as pharmaceutical alternatives. Such products are not considered to be therapeutically equivalent. There are known instances in this List where pharmaceutical alternatives are coded as therapeutically equivalent. Anhydrous and hydrated entities are not considered as pharmaceutical equivalents unless they meet the same standard and, as in the case of ampicillin, their equivalence is supported by appropriate bioavailability/bioequivalence studies where necessary.

5. Drug products that are solids for reconstitution, diluted solutions, or concentrated solutions, and that contain different concentrations of active ingredients, are not considered pharmaceutical equivalents. Of course, the exercise of accepted professional practice may render pharmaceutically different concentrations into pharmaceutical equivalents (e.g., concentrated solutions may be diluted to lower strengths by using proper procedures designed to maintain the quality of the product).

6. Where package size variations have therapeutic implications, products so packed have not been considered pharmaceutically equivalent. For example, some oral contraceptives are supplied in 21- and 28-tablet packets; the 28-tablet packs contain 7 placebo or iron tablets. These two packaging configurations are not regarded as pharmaceutically equivalent; thus they are not designated as therapeutically equivalent.

The specific sub-codes for those drugs evaluated as therapeutically equivalent and the policies underlying these codes are listed below:

AA Products Not Presenting Bioequivalence Problems, In Conventional Dosage Forms: Products coded as AA are standard formulations of these active ingredients that are not regarded as presenting either actual or potential bioequivalence problems. In addition, the drug products of the active ingredient are manufactured in dosage forms not presenting bioequivalence problems, such as plain tablets, capsules, solutions, elixirs, syrups and tinctures.

An example of a product in this category is:

Syrup: Oral
 ATARAX
 AA Roerig/Pfizer 10mg/5ml
 HYDROXYZINE HCL
 AA National/Barre 10mg/5ml

AB Products Meeting Necessary Bioequivalence Requirements

The AB evaluation denotes products that contain an active ingredient in a dosage form that is subject to a bioequivalence requirement, or for which the submission of bioavailability data is required for approval, and for which the application holder has provided adequate studies to support the bioavailability and bioequivalence of its product. This category also includes those few drugs with more than one application holder but only one manufacturer. It should be noted that if only one product under a drug ingredient heading is coded AB, it signifies that only that product is supported by bioavailability data. It does not signify that this product is therapeutically equivalent to the other drugs under the same heading. Thus, one product of a drug ingredient heading, coded AB, is not therapeutically equivalent to a drug product under the same heading that is coded BD or BO. Only those drugs coded AB under the ingredient heading are considered therapeutically equivalent to each other.

An example of a product in this category is:

HYDROCHLORTHIAZIDE; SPIRONALACTONE		
	Tablets: Oral	
	ALDACTAZIDE	
AB	Searle	25mg;25mg
	SPIRONALACTONE-HYDROCHLORTHIAZIDE	
AB	Mylan Pharms	25mg;25mg
AB	Bolar Pharm	25mg;25mg
AB	Cord Labs	25mg;25mg
AB	Zenith Labs	25mg;25mg

AN Solutions and Powders for Aerosolization

Uncertainty regarding the therapeutic equivalence of aerosolized products arises primarily because of differences in the drug delivery system. Powders or solutions for aerosolization which are marketed for use in any of several delivery systems are considered to be pharmaceutically and therapeutically equivalent and are coded AN. Those products compatible only with, or which are a component of, a specific delivery system are classified BN, because drug products in their respective delivery systems are not necessarily pharmaceutically equivalent and therefore not therapeutically equivalent.

EXAMPLE

ISOETHARINE HYDROCHLORIDE		
	SOLUTION: INHALATION	
	BRONKOSOL	
AN	BREON LABS/STERLING	0.25% x 1%
	ISOETHARINE HCL	
AN	DEY LABS	1%
AN	INT'L MEDICATION SYS.	0.25% x 1%
		0.077% x 0.0833%
		0.167% x 0.2%
AN	PARKE-DAVIS/H-L	1%
		0.5%
AN	PHILIPS ROXANE LABS	1%

AO Injectable Oil Solutions

The absorption of drugs in injectable oil solutions may vary substantially with the type of oil employed as a vehicle and the concentration of the active ingredient. Injectable oil solutions are therefore considered to be pharmaceutically and therapeutically equivalent only when the active ingredient, its concentration, and the type of oil used as a vehicle are all identical.

EXAMPLE
ESTRADIOL VALERATE

	INJECTABLE/INJECTION
	DELESTROGEN
AO	ER SQUIBB AND SONS 10MG/ML X 20MG/ML X 40MG/ML
	ESTRADIOL VALERATE
AO	CARTER-GLOGAU LABS 10MG/ML X 20MG/ML X 40MG/ML
AP	Aqueous Injectable (Parenteral) Solutions

All injectable products are listed under the general category *Injectable; Injection*, but specific routes of administration are not shown. Some multisource products that are pharmaceutical equivalents are labeled by their different application holders for different routes of administration. Infectable products available as dry powders for reconstitution, concentrated sterile solutions for dilution, or sterile solutions ready for injection, are all considered to be pharmaceutically and therapeutically equivalent provided they are designed to produce the same concentration for injection and are equivalently labeled. Consistent with accepted professional practice, it is the responsibility of the prescriber, dispenser, or individual administering the product to to be familiar with a product's labeling to assure that it is given only by the route(s) of administration stated in the labeling.

Certain commonly used large volume intravenous products are not included on the List (e.g., dextros 5% with water, dextrose 10% with water, sodium chloride 0.9% injection). Virtually all of these drug products came on the market in glass containers before 1938 and have not been required to obtain an approved new drug application as a condition of marketing. When packaged in plastic containers, however, these same drug products are considered to be new drugs requiring approved new drug applications for marketing. All large volume parenteral products are manufactured under similar standards, regardless of whether they are packaged in glass or plastic. Thus, FDA has no reason to believe that the packaging container of large volume parenteral drug

products that are pharmaceutically equivalent would have any effect on their therapeutic equivalence.

EXAMPLE
ALCOHOL; DEXTROSE

	INJECTABLE; INJECTION
	ALCOHOL 10% AND DEXTROS 5% IN DISTILLED WATER
	AM MCGAW/AM HOSP 10ML/100ML; 5GM/100ML
	ALCOHOL 5% AND DEXTROSE 5% IN DISTILLED WATER
AP	AM MCGAW/AM HOSP 5ML/100ML; 5GM/100ML
	ALCOHOL 5% IN DEXTROSE 5%
AP	CUTTER LABS 5ML/100ML; 5GM/100ML
	ALCOHOL 5% IN DEXTROSE 5% IN WATER
AP	TRAVELNOL LABS 5ML/100ML; 5GM/100ML
	ALCOHOL 5% IN D5-W
AP	ABBOTT LABS 5ML/100ML; 5GM/100ML
AT	Topical Products

There are a variety of dosage forms available for topical, ophthalmic, otic, rectal and vaginal administration, including solutions, creams, ointments, gels, lotions, pastes, sprays, and some suppositories. Different topical dosage forms are not pharmaceutically equivalent even though they may contain the same active ingredient, and, therefore, they are not considered therapeutically equivalent. Products in the same topical dosage forms are, however, in the absence of contrary data, considered therapeutically equivalent if they are pharmaceutically equivalent.

EXAMPLE
AMINOACETIC ACID

	AMINOACETIC ACID 1.5% IN PLASTIC CONTAINER
AT	AM MCGAW/AM HOSP 1.5GM/100ML
AT	TRAVENOL LABS 1.5GM/100ML
	GLYCINE 1.5% IN PLASTIC CONTAINER
AT	ABBOT LABS 1.5GM/100ML

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Jurisprudence Self-Test

by
Melvin Rubin

Pharmacists are called on many times a day to make decisions which will provide needed medication while staying within the limits of a myriad of federal, state, and local laws. These decisions have to be made automatically and rapidly, so it is appropriate to stop occasionally and review the laws. See how well you perform on this self test.

1. Labeling:
 - a. What must be on the prescription label?
 - b. How must the label be attached to the container?
2. Time Limit:
 - a. How long after a prescription is written may it be filled for the first time?
 - b. What is the exception to this time limit?
3. Product Selection:
 - a. Under what conditions may a pharmacist dispense a brand other than that prescribed by the physician?
4. Syringe Law:
 - a. What records must be maintained related to selling syringes?
 - b. What other items fall under this same law?
5. Copy law: Under what conditions may a pharmacist fill a copy of a prescription
 - a. taken orally over the phone?
 - b. given to him in writing by a patient?
6. Safety Closures:
 - a. Under what conditions are safety closures *not* required?
 - b. Are reversible closures legal?
7. Ipecac: Under what conditions may Ipecac be sold?
8. Refrigerator: What temperatures are allowable in
 - a. refrigerator?
 - b. freezer?
9. Controlled Dangerous Substances:
 - A. Under what conditions may a schedule III or IV drug be refilled
 - 1) pursuant to refill instructions on the original prescription?
 - 2) pursuant to physician oral authorization for addition refills?
 - B. What is the procedure for filling a Schedule II drug on oral authorization?
- C. How can partial fillings of Schedule II items be handled?
 - 1) when patient requests the partial?
 - 2) when pharmacy does not have enough doses to fill complete Rx?
- D. What procedures must be followed to keep CDS records away from the pharmacy?
- F. Under what conditions may a pharmacy distribute CDS items to
 - 1) another pharmacy?
 - 2) a physician?
- F. What security measures must be taken to deter theft
 - 1) in storage of CDS items?
 - 2) regarding personnel?
- G. Inventory requirements
 - 1) when must inventory be taken and how often?
 - 2) how accurate must the counts be for Schedule II, and for Schedule II, IV, and V?
 - 3) what information must accompany the inventory list?
- H. What information must appear on the prescription on your file?
- I. Under what conditions may an intern, resident, or unlicensed foreign physician write a prescription?
- J. Under what conditions may a physician prescribe the following and what are the responsibilities of the pharmacy?
 - 1) Methamphetamine
 - 2) Amphetamine
 - 3) Ritalin or Preludin
- K. How is the sale of "emempt narcotics" (i.e. Terpin Hydrate Codeine) handled in Maryland (2 part answer)?
- L. If Federal law is more lenient than local law, which prevails?
- M. If an automobile is found to contain CDS items in violations of laws allowing possession, distribution etc., what rights does the owner of the vehicle have?

Answers to Self-Test on
following page.

Answers to Jurisprudence Self-Test

(references — Maryland Pharmacy Law Book and Pharmacists Manual
— An Informational Outline of the Controlled Substances Act of 1970.
Available from district office of D.E.A.)

- 1 The prescription label must contain in addition to name of patient, directions of prescriber, name of prescriber, date of filling and identification number, also the name and strength of the medication prescribed, the expiration date of the medication (maximum one year from date of filling), and appropriate special handling instructions regarding proper storage. Name and Strength may not be shown if prescriber so indicates.
 - b. The label must be affixed to the outside of the container, not dropped in the vial.
- 2
 - a. A prescription may be filled if presented to pharmacist within 120 days of date written.
 - b. Pharmacist may call physician for permission to fill beyond this time limit and so indicates on the prescription.
- 3 A pharmacist may dispense a different, lower cost, drug product of the same dosage form and strength if the different drug product is generically equivalent. The patient must be notified in writing of the interchange, the pharmacist must record on the prescription record the name and manufacturer of the drug product dispensed, and the interchange must be made from a formulary established by the Department of Health. If the prescriber indicates that the prescription is to be dispensed as directed, no brand change may be made. Under all circumstances pharmacist may make changes with express authorization of prescriber.
- 4 The sale of needles and syringes or other paraphernalia shall be made by the pharmacist only in good faith to patients showing proper identification and indication of need. The record of sale must be kept in a registry and indicate the name and address of purchases, date of sale, item and quantity and signature of pharmacist. Generally anything which might be used to help with injection or diluting drugs such as empty capsules or lactose powder is considered to be 'paraphernalia'.
- 5 A copy of a prescription may be given orally from one pharmacist to another provided that pharmacist giving copy records name of pharmacy, pharmacist and the date of transfer and he voids his prescription. Pharmacist receiving copy must record name of transferring pharmacy, pharmacist, and date received. A written copy cannot be honored by another pharmacy.
- 6 Safety closures are not required for exempted drugs such as sublingual nitroglycerin and isosorbide, and are not required if the patient or prescriber indicates they do not want them. It may be advisable to have this exemption request in writing. Although reversible closures are being questions as properly safe, they are legal at this time.
- 7 Ipecac may be sold in 1 oz. bottles only.
- 8 USP standards for freezer are -20° to 10° C (-4-14 F) and for refrigeration 2°-8° C (36°-46° F).
- 9
 - A. Schedule III, IV, or V drug may be refilled a maximum of 5 times within a maximum of 6 months provided the prescriber authorized this on the original prescription order either in writing or orally. A prescriber, when orally authorizing additional refills is technically issuing a new prescription order; therefore you must reduce this to writing as a new prescription.
 - B. On receiving a bonafide oral order for a Schedule II drug, the pharmacist must reduce this to writing immediately and may dispense only enough doses to meet the emergency. The prescriber must make the written prescription available within 72 hours. If he does not, and the pharmacist does not report this to authorities he is responsible.
 - C. When patient requests a partial filling of a Schedule II drug the balance is voided. If the partial filling is a result of the pharmacist not being able to supply the entire quantity, balance may be delivered within 72 hours or balance voided.
 - D. In order to keep CDS records at a central location or anywhere away from the pharmacy, a request must be made to the district D.E.A. office and in absence of reason to deny the permit, you will be allowed to do so. Records must be produced within two working days on D.E.A. request.
 - E. A pharmacy may distribute Schedule III, IV or V drugs to another pharmacy or to a dispenser without a distributors license provided that these transactions represent no more than 5% of the pharmacy yearly purchases, provided that the pharmacy or physician is registered to dispense controlled substances, and provided that full records are kept similar to prescription records. Schedule II drugs may be distributed as above but the records must be kept on a Schedule II order form in which the pharmacy is the distributor.
 - F. CDS items must be stored in a locked cabinet or dispersed throughout inventory. They may not be grouped in an unlocked section. Maryland regulations for CDS security in pharmacies includes limiting the prescription department to pharmacists, pharmacy students and other personnel specifically authorized by the registrant. Employees who have had CDS registration revoked are not allowed access to controlled substances.
 - G. Federal law requires a biennial inventory on May 1. (1981 is an inventory year), but allows the pharmacy to request a different date. Each biennial inventory should not vary more than 4 days from the preceding one without permission. Schedule II items must be counted, measured, or weighed exactly. Schedule III, IV, and V items may be estimated unless the container holds more than 1000 dosage units, in which case an exact count is required. The inventory list must contain the name, address, and DEA registration number, indicated dated and time taken (such as opening or close of business), and be signed by person responsible for taking it. Schedule II inventory has to be separate and records must be maintained for at least two years.
 - H. CDS prescriptions on file must contain the name, address and DEA number of prescriber, date written, date filled and initials of dispenser (Maryland law requires this on all prescriptions, not just CDS), and in the cases where scheduled items are on file with other prescriptions, a red C one inch must be stamped in lower right hand corner.
 - I. Interns, residents, and foreign physicians may prescribe CDS drugs in the usual course of professional practice provided the hospital or institution permits this, and providing he uses their DEA number and the specific suffix assigned to him by the hospital or institution, and a current list of internal codes are kept on file at the hospital or institution.
 - J. Amphetamine may be prescribed for Narcolepsy, Hyperkinesia, in cases of exceptional obesity provided the prescriber documents the use to the Department, and in cases of medical need as determined by the department. Diagnosis in all cases must appear on the patient record maintained by the physician. Amphetamines and Methamphetamines are restricted to 100 doses or 34 days supply maximum. Ritalin and Preludin are not affected by the above even though uses may coincide.
 - K. Terpin Hydrat & Codeine and other Schedule V cough syrups may be sold in Maryland provided an exempt narcotic book is filled out by the pharmacist in all subdivisions except Baltimore City and Baltimore County. In those areas they are treated as if they were Schedule IV.
 - L. The more stringent law applies in all cases, unless Federal law specifically overrides a state. This has not been applied to any pharmacy laws.
 - M. A motor vehicle containing CDS items in violation of laws may be seized by the State and the owner would forfeit any property rights.



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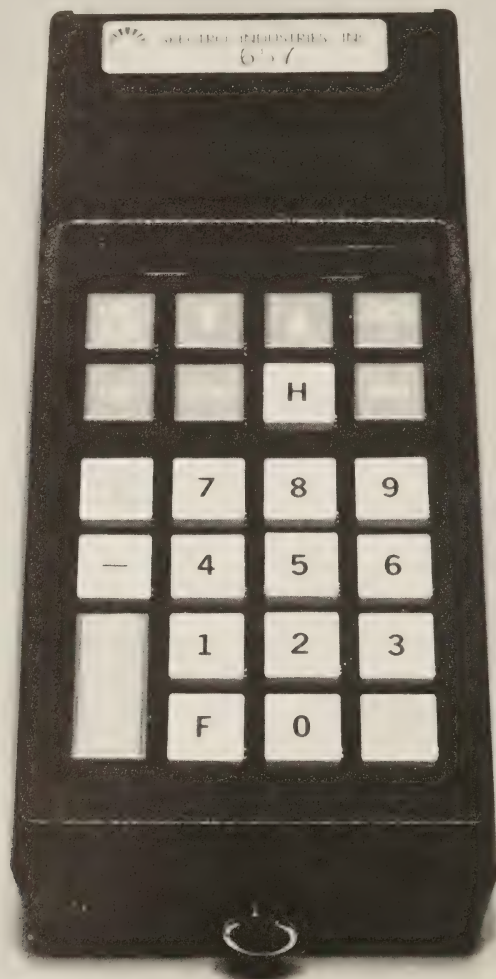
And when the 10 weeks were over, we parted knowing that we'll enjoy seeing each other in the years ahead.

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MORRIS R. YAFFE

1913-1980



Morris R. Yaffe, 67, a pharmacist dedicated to the advancement of his profession, died on December 6, 1980. He was a past president of the Maryland Pharmaceutical Association, the Maryland Board of Pharmacy, and the Prince-Georges Montgomery County Pharmaceutical Association. He had served on the MPhA Executive Committee from 1958 to 1970.

A native of Baltimore, Mr. Yaffe received his B.S. in Pharmacy from the University of Maryland in 1936. He operated a pharmacy in Bethesda for nine years, followed by ownership of the Potomac Village Pharmacy near Rockville for 22 years. The pharmacy was noteworthy for the extraordinary efforts to serve its clientele in the traditional personalized manner of the "corner" pharmacist. Morris gained the respect, confidence, and admiration of his clientele. He was an "institution" in the community to whom all turned for help when problems arose. In 1979 he sold his pharmacy and retired.

Mr. Yaffe was one of the pioneers in organizing pharmacists in the Prince Georges — Montgomery counties area. He was a founder of the area association and served as its second president.

He served on the Montgomery County Advisory Committee to the Health Department on Medical Care for six years and was president for two years. He represented pharmacy on the special committee on Medical Services of the Advisory Board to the Montgomery County Council for three years, acting as its chairman for one year.

Mr. Yaffe served as a member of the Pharmacy Services Committee of the State Council on Medical Care of the State Health Department.

He was recognized by his neighbors by election as President of the Potomac Chamber of Commerce.

Mr. Yaffe served as president of the Maryland Pharmaceutical Association for 1966-67 after serving as Chairman of the Membership Committee for two years, of the Annual Convention Committee and on many other committees, particularly the Legislative Committee.

In 1966 he was appointed to the Maryland Board of Pharmacy. He was reappointed in 1971 and elected as president of the Board in 1973 until the completion of his second term in 1976.

During his presidency of MPhA he played a prominent role in the enactment, after several years of effort, of greatly needed pharmacy legislation. The 1967 act resulted in a definition of "the practice of pharmacy", improvement of the de-

finition of "a pharmacy", and authority for the first time for the Board of Pharmacy to promulgate regulations governing the practice of Pharmacy and the operation of pharmacies.

Mr. Yaffe's tenure also included a substantial increase in the medical care prescription fee and the adoption of a single professional fee for the first time in the State program. Also, at this time PHARMPAC — the Pharmacist's Political Action Committee was established.

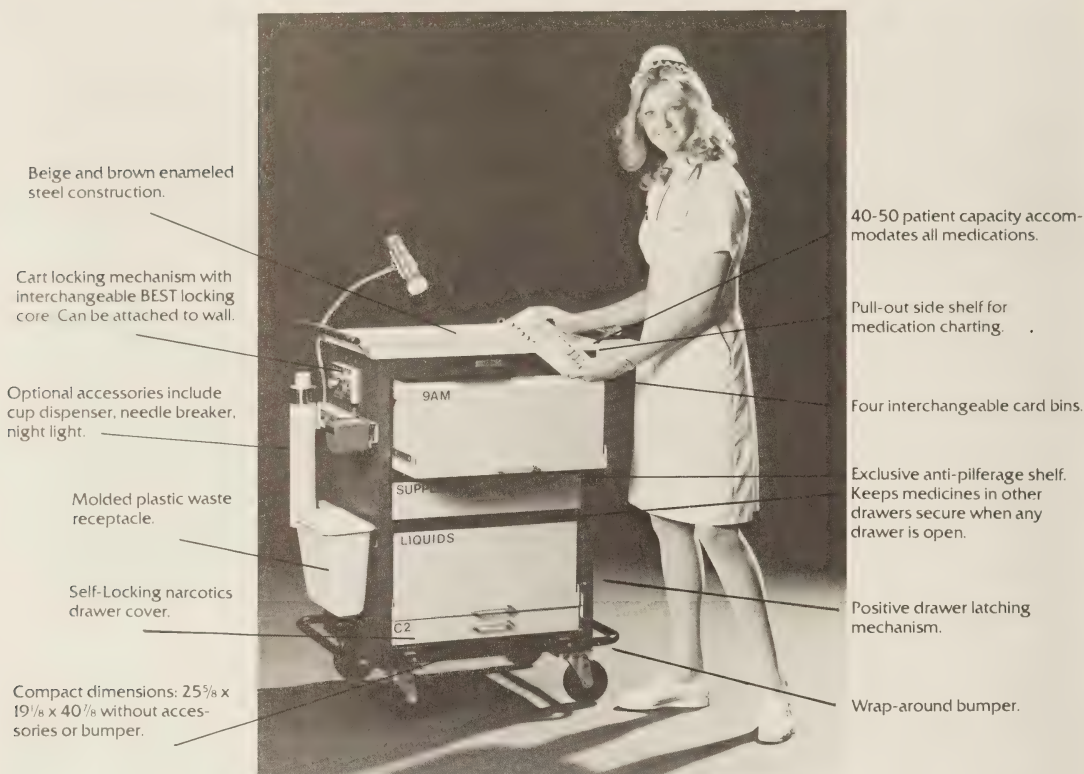
Morris Yaffe was a devoted family man. His wife, Edna, worked closely with him in all his pharmacy endeavors. Also surviving are his children: daughter, Leslie Marks, and two sons, Samuel and Bruce Yaffe; a brother Samuel Yaffe; and three grandchildren.

For many years Morris Yaffe devoted most of his spare time to strengthening pharmacy organizationally, professionally and legislatively. In his pharmacy practice he set high standards of personalized community service as a vital member of the health care team. He was committed to the concept of the pharmacist as an integral part of health care.

Morris Yaffe's patrons, neighbors, professional colleagues and his peers recognized his dedication and will miss him.

*Nathan I. Gruz
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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

FUROSEMIDE-ASPIRIN INTERACTION:

Patients were given furosemide (Lasix) and the diuretic effects were monitored and recorded. They were then pretreated with large doses of aspirin and once again given the diuretic. The response to furosemide in the salicylate treated patient is less than that observed when the analgesic is absent. The mechanism involved is apparently independent of the ability of aspirin to inhibit the synthesis of prostaglandins. The investigators feel it acts by competing with furosemide for active secretion into the urine and thus the salicylate will reduce the amount of the diuretic which reaches the kidney. *J CLIN PHAR*, Vol. 20, #7, p. 452, 1980.

EXPLOSIVE ANESTHETICS:

Ether, cyclopropane, and chloroform have been used extensively as general anesthetic agents for many years, but their popularity has been on the decline since the introduction of safer agents in the mid-1950's. When halothane and methoxyflurane (Penthrane) were first marketed, virtually every hospital in America was using explosive anesthetic agents. Today less than 15% of those institutions use the more dangerous drugs. Widespread use of electrical equipment including electrocautery and monitoring devices has helped convince physicians to abandon the older agents. As the demand for these drugs declines, the cost per administration increases. The authors of this article suggest that the use of explosive anesthetic agents be discontinued completely. *N ENG J MED*, Vol. 303, #11, p. 613, 1980.

GENETIC VARIATION IN DRUG RESPONSE:

Certain alterations have been noted to occur in the metabolism of people of different races. Orientals have increased sensitivity to ethanol and many are capable of acetylating drugs at a rapid rate. The drug diphenhydramine (Benadryl) was administered to both Oriental and Caucasian volunteers. The effect of the drug was monitored along with the plasma level. It was noted that Oriental patients experienced less sedation and deterioration in psychomotor performance than did Caucasian volunteers. Plasma analysis yielded information which indicates that the plasma level of the antihistamine in Oriental people is approximately one-half of the level seen in Caucasians given the drug in the same dose and by the same route of administration. *CLIN PHARM*, Vol. 28, #2, p. 229, 1980.

INTERFERON:

Interferon obtained from human leucocytes was used to treat patients with metastatic breast cancer, multiple myeloma and malignant lymphoma. Approximately one-half of the patients in each group responded to therapy as measured by tumor regression. The drug was used in these advanced cancer situations with some success and thus it has been suggested that it might be better utilized before the growths reach such an advanced stage. *ANN INT MED*, Vol. 93, #3, p. 399, 1980.

RANITIDINE:

A molecular variant of cimetidine, ranitidine has been compared to the older drug in patients with duodenal ulcers. The new drug was effective, but did not increase serum urea or creatinine as is often noted with cimetidine administration. *BR MED J*, Vol. 6238, #281, p. 473, 1980.

COLONIC MOTILITY:

Colonic motility is increased by acetylcholine, serotonin, norepinephrine, and dopamine. The use of haloperidol (Haldol), a dopaminergic blocking agent, has been shown to reduce nervous diarrhea, etc. in approximately 83% of non-psychotic patients. However, only 10% of psychotic patients noted this antidiarrheal response to haloperidol. Their diarrhea did respond to three different antidiarrheal agents, including phenotolamine (Regitine) and clonidine (Catapres). It is suggested that schizophrenic patients may possess an overactivity of the adrenergic system in this peripheral tissue. *J CLIN PHAR*, Vol. 20, #7, p. 459, 1980.

ESTROGENS AS POST-COITAL CONTRACEPTIVES:

Ethinyl estradiol and conjugated estrogens were used as post-coital contraceptives in a group of over 1000 women. The drugs were administered for five days starting within 72 hours after intercourse. The ethinyl estradiol produced complete protection but the conjugated estrogens were less effective. Nausea occurred in 70% of the women and one-third of them experienced vomiting. *J AM MED A*, Vol. 244, #12, p. 1336, 1980.

TETRACYCLINE ABSORPTION:

The administration of antacids which contain divalent and/or trivalent cations will reduce the absorption of concomitantly administered tetracycline by complexing the antibiotic into an insoluble form. Administration of sodium bicarbonate solution will interfere with the dissolution of the antibiotic and thus also prevent complete absorption. Cimetidine (Tagamet) was administered to patients receiving tetracycline in order to determine if the reduction in acidity itself was preventing the absorption. Results of plasma analysis indicate that tetracycline can be administered along with cimetidine without interfering with the absorption of the antibiotic. *CLIN PHARM*, Vol. 28, #2, p. 203, 1980.

CONVERTING ENZYME INHIBITORS:

Two drugs have been used because of their ability to inhibit converting enzyme, the protein which converts inactive angiotension I to the potent vasoconstrictor angiotension II. Teprotide is not effective orally and requires intravenous administration to be effective. Captopril is not without serious side-effects. Currently minoxidil is preferred for resistant cases of hypertension, but the development of less toxic converting-enzyme inhibitors is of high interest. *BR MED J*, Vol. 281, #6241, p. 630, 1980.

PROPOXYPHENE NAPSYLATE:

Approximately 130 narcotic addicts were treated with doses of propoxyphene napsylate that ranged from 400 to 1400 mg. daily. Side effects were minimal at plasma concentrations which normally would produce toxic effects. This is thought to be due to tolerance which builds up with constant narcotic use. Propoxyphene napsylate seemed to work best in patients who could be controlled with low doses of methadone. *CLIN TOXIC*, Vol. 16, #4, p. 473, 1980.

DIGOXIN AND DOBUTAMINE:

In patients who have experienced an acute myocardial infarction and heart failure, the drug of choice for some time has been digoxin (Lanoxin). A comparison has been made between digoxin and dobutamine (Dobutrex) in patients with this condition and the authors of this article feel that the beta adrenergic stimulant is the preferred drug. Dobutamine has a rapid onset of action and a short duration. This makes its activity easy to terminate if problems arise. Digoxin takes much longer to work and has a half-life of approximately 30 hours. Patients receiving dobutamine experience a markedly increased cardiac output, decreased filling pressure, and relieved pulmonary congestion. *N ENG J MED*, Vol. 303, #15, p. 846, 1980.

INTRATHECAL MORPHINE:

Twelve women who were about to give birth were given morphine intrathecally. Pain was abolished without producing unconsciousness. *BR MED J*, Vol. 281, #6236, p. 351, 1980.

HALLUCINOGENS:

The mechanism of action of LSD, dimethyltryptamine, and mescaline has been studied in animals and is thought to be identical in each case. Investigators have found that each drug is capable of acting as a serotonin agonist. Methoxyamphetamine, also a hallucinogen, is thought to exert its effects by allowing for the release of endogenous serotonin from nerve endings in the central nervous system. *J PHARM EXP*, Vol. 214, #2, p. 231, 1980.

LEUKEMIA:

Patients who suffer from leukemia may experience a remission of symptoms only to later find therapy was not successful, and a relapse in the disease is noted. Using a technique which will determine the presence of premature chromosomal condensation (PCC), investigators feel they will be able to more accurately predict if a patient has been cured or if they are only in a remission stage. The majority of the patients studied who later experienced a relapse were identified prior to the relapse by using the PCC technique. Investigators hope their method will be a useful and accurate way of detecting those most likely to experience a relapse in leukemia. *N ENG J MED*, Vol. 303, #9, p. 479, 1980.

ASPIRIN:

Aspirin is used frequently by many people to help control symptoms of minor pain, inflammation and/or fever. For years, everyone has been made aware of the fact that aspirin can produce irritation of the gastrointestinal tract. Some investigators feel this concern is often excessively stated and have reappraised the effect of aspirin on the stomach. They have concluded that aspirin ingestion rarely causes clinically significant gastric damage in normal patients. It does so only

when large doses are consumed or when the patient used the drug frequently. Aspirin should continue to be used with caution in patients with gastrointestinal disease. *LANCET*, Vol. II, #8191, p. 410, 1980.

HEPARIN-DIAZEPAM INTERACTION:

Administration of small amounts of heparin have been shown to increase the amount of diazepam found in the plasma. Investigators found not only an increase in the concentration of the free drug, but also an increase in the amount of free desmethyldiazepam, an active metabolite. It has been suggested that heparin releases diazepam from tissue binding sites and thus elevates the plasma level of the anxiolytic. *CLIN PHARM*, Vol. 27, #4, p. 528, 1980.

TARTRAZINE:

Tartrazine (FDC Yellow #5) is a dye used to color food, drink and drugs. Some people have shown sensitivity to the dye which can manifest itself as urticaria, acute asthma, and non-thrombocytopenic purpura. This has been seen more frequently in patients allergic to aspirin. It is suggested that action be taken to disclose the presence of tartrazine in all products. *DRUG THER B*, Vol. 18, #14, p. 53, 1980.

INDOMETHACIN:

Indomethacin (Indocin) is a potent inhibitor of prostaglandin synthesis and has been said to increase blood pressure by preventing the synthesis of prostaglandins which act as vasodilators. In order to determine what effect it might have on patients receiving propranolol or a thiazide diuretic, indomethacin was administered to patients who previously had blood pressure readings recorded. In both sets of patients, indomethacin produced a partial reversal of the antihypertensive effects of these drugs. *BR MED J*, Vol. 281, #6242, p. 702, 1980.

GENERALIZED PRURITIS:

Patients with renal disease often experience generalized pruritis. Therapy for this condition consists of cholestyramine resin (Cuemid, Questran) which helps remove bile salts and other materials from the gastrointestinal tract, but it also interferes with the absorption of various drugs and can produce disturbances in bowel function. Intravenous lidocaine can also help alleviate the itching, but this is a rather dangerous drug to be using as an antipruritic. The use of phototherapy requires time and is relatively expensive, but has been beneficial in some cases. Researches in Oklahoma have found activated charcoal to work well in reducing generalized pruritis in dialysis patients. The drug was used in daily doses of six grams without producing any adverse reactions. Activated charcoal seems to be a safer and less expensive alternate to current therapy for generalized pruritis. *ANN INT MED*, Vol. 93, #3, p. 446, 1980.

CIMETIDINE:

Histamine has been found in pancreatic tissue, where its role is still ill-defined. Investigators in Minnesota feel that histamine may play a role in promoting insulin secretion. Histamine injections into the pancreatic artery of dogs will stimulate insulin release. Patients receiving intravenous cimetidine have been noted to experience glucose intolerance and thus it is suggested that H-2 stimulation may play a role in insulin release. *CLIN PHARM*, Vol. 28, #3, p. 392, 1980.

Maryland Poison Prevention Week Focuses on Pharmacists Involvement

"An Ounce of Prevention"

Syrup of Ipecac

The Maryland Poison Center's
Directions for Ipecac Syrup

Syrup of Ipecac is a non-prescription medicine used to cause vomiting in children and adults in case of poisoning. Keep Ipecac Syrup in your medicine chest, but before using it always call:

The Maryland Poison Center
(301) 528-7701
Metropolitan Baltimore
(1) 800-492-2414
Elsewhere in Maryland

Directions for Use:

- (1) Call the Maryland Poison Center to check if Syrup of Ipecac is necessary to give;
- (2) Give one TABLESPOON (half the 1 oz. bottle);
- (3) Follow immediately with at least 6-8 oz. of water;
- (4) Vomiting should occur in approximately 15-20 minutes.

CAUTIONS:

NEVER GIVE SYRUP OF IPECAC AT HOME IF:

- (1) you have not called the Maryland Poison Center or your doctor;
- (2) the patient is less than one year of age;
- (3) the patient has a history of seizures or is having a seizure;
- (3) the patient is drowsy, asleep, or unconscious;
- (4) the patient has a history of seizures or is having a seizure;
- (5) the patient has burns in or around the mouth;
- (6) the patient is having difficulty swallowing;
- (7) the product taken is a corrosive (lye, drain cleaner, strong acid or base, etc.);
- (8) the product taken is a petroleum distillate containing product (kerosene, gasoline, paint thinner, furniture polish).

Prepared by the Maryland Poison Center, University of Maryland,
School of Pharmacy.

Printed as a public service by the
Maryland Pharmaceutical Association.

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and District Wholesalers.



President Reagan has designated the week of March 15-21, 1981 as National Poison Prevention Week. As part of Maryland's observance, Maryland Poison Center (MPC) staff will be involved in consumer education programs, distribution of educational materials, media appearances, and promotion of state-wide poison prevention activities. Your role as pharmacists places you in a unique position to encourage members of your community to practice active poison prevention techniques and thus decrease the number of accidental poisonings. In 1980, MPC pharmacists handled over 42,500 calls, of these 29,344 were actual exposures. The majority of these were accidental, occurring in the home and involving children under the age of 5. Since the MPC believes that many of these incidents could have been prevented, our educational materials are geared to the parents and caretakers of young children. Telephone stickers and information sheets are available from the MPC in limited quantities to pharmacists who wish to actively promote poison prevention during March. Because of Syrup of Ipecac is the only emetic recommended by the MPC and the FDA, pharmacists are encouraged to educate parents on the need to keep Syrup of Ipecac in the home *before* the poisoning occurs. To aid you in this task, the MPC through the generosity of the Maryland Pharmaceutical Association has prepared a "bag stuffer" on Syrup of Ipecac and its use. During Maryland Poison Prevention Week, we are asking you to distribute this bag stuffer to your community, especially to those purchasing Ipecac Syrup. (See the sample on this page.) Davis and Calvert, Loewy and District Wholesalers will deliver these with your order during the third week in March.

Several pharmacies have already notified the MPC of their proposed Poison Prevention Week projects, such as the Medicine Shoppe (rebates on old prescription vials), Peoples, Randallstown Professional Pharmacy and Giant Pharmacies. If you are planning an activity or promotion for MPPW, we will be happy to promote it. We would appreciate receiving photographs (preferably, black and white, glossy) of any exhibits, learning centers, programs, that you might have, etc., so that it may appear in a future *Maryland Pharmacist* and/or possibly other community publications. Don't hesitate to send photos with captions to your local paper. For more information, contact Jacquie Lucy or Karen Disney at the Maryland Poison Center (301) 528-7604 (administrative phone) between 8:30 a.m. to 4:30 p.m. Monday-Friday.

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All MPhA members should have received their *Hertz Discount Card* in a recent mailing. See page 29 of this issue for information on the discounts available and if you did not get a card — call the office.

Remember — if you see a Maryland car license plate with the numbers "RXA" — honk because it will be another pharmacist. Contact the office if you are interested in having a reserved license plate.

The Dental Association has set up an "Impaired Dentist" program for rehabilitating the chemically dependent Dentist. Inquiries can be made at (301) 796-8441 and are confidential. This program is similar to one which was set up by the physician's association.

Member Paul Rezek has been elected to serve as Vice President of the APhA Credit Union. Congratulations Paul.

The Continuing Education Coordinating Council wishes to thank the Sub Committee on Planning for its outstanding work. They were: Wendy Klein-Schwartz, Chairperson, Suzanne Bristow, Bill Grove, Lucy King, Glenn Miles, Marvin Oed and Craig Svensson.

The Centennial Committee wants old photographs of drug stores, apothecary shops or pharmacies no longer in existence. The photos should be positively identified as to street address, name of store at the time of the photo, and the name of the person who can verify the information. Photos will be used during 1982 as part of a public identification contest.

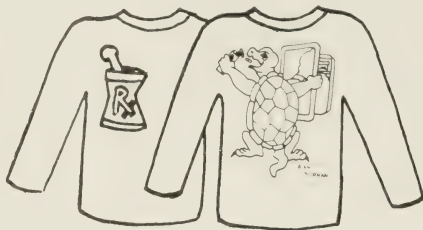
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Student graduating in class of 1981 seeks employment. Three years pharmacy experience. Educational background in Geriatrics, Community Management, and Computers. Resume and references on request to Box 4, Maryland Pharmaceutical Association Office.

calendar



- FEB. 8 — BMPA — Annual Dinner Dance — Bluecrest, Reisterstown Rd.
- FEB. 26 — CECC Program "Geriatrics" — Baltimore Convention Center
- MAR. 1 — AZO Dinner Meeting, Shane's in Towson
- MAR. 5 — SAPhA Program — "Computers in Pharmacy", Holiday Inn, Cromwell Bridge
- MAR. 12 — MPhA SPRING REGIONAL — INTERNATIONAL HOTEL, BWI AIRPORT
- MAR. 19 — CECC Program — "Primary Care" — Kelly Memorial Building
- MAR. 22 — Fritz Berman Seminar — "Psychiatry, Neurology and the Pharmacist"
- MAR. 28-APR. 1 — APhA Annual Meeting in St. Louis
- APRIL 30 — CECC Program — "Antibiotics"
- JUN. 19-21 — MSHP Annual Convention — Ocean City
- JUN. 21-25 — MPhA CONVENTION — CAROUSEL, OCEAN CITY

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Use of DMSO

The New FDA Drug List

How Much is Enough?

—Lilly Study

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This month brings the Association even closer to the Centennial year. As plans are completed for this year's 99th Annual Convention, we must look toward June, 1982 for the Centennial convention.

Let us remember and commemorate the past endeavors of the Association while we live and work in the present and attempt to envision and plan for the future of the Profession in Maryland.

Many thanks to Dave Banta and the legislative committee for a most active effort in Annapolis again this year. They join me in thanking any and all Pharmacists who have actively met with state legislators to further our causes. The realization that we cannot hope to accomplish our goals by allowing others to do our work has helped our efforts.

Our convention will be full of interesting and vital issues in addition to continuing education programs. Be prepared to discuss and act on these issues.

Post your signs and notices to bearers of stolen and forged prescriptions — we will no longer put up with the constant hassle. A concentrated effort by Pharmacists can force a change of tide. Don't just send them away, report them, go to court and help put them away. The police and courts will take notice and join the effort. It won't be easy. Many thanks to S.A.Ph.A. and its members for continued and expanded activity.

Keep the cards and letters (and phone calls) rolling in, the association needs to be aware of your interests and needs. The attendance at the March 12 Spring Regional was an indication of the increased interest of our members. I will talk to you next month.

Samuel Lickter



Use of **DMSO**

for unapproved indications

The increasing use and promotion of dimethyl sulfoxide (DMSO) for uses for which it has not been shown to be safe and effective are of concern to FDA.

The product is currently available in three forms and concentrations:

- A 50 percent solution approved in 1978 for installation in the urinary bladder in the treatment of symptoms of interstitial cystitis.
- A 90 percent solution approved in 1970 as a veterinary medication for topical use in nonbreeding dogs and horses.
- A 99 percent solution marketed for many years as an industrial "degreaser solvent."

The Agency is particularly concerned about the use of the veterinary and industrial products by people treating themselves topically and orally for a host of conditions, including arthritis, bursitis, tendinitis, and muscular sprains and strains.

When rubbed on the body, DMSO in concentrations above 50 percent can cause erythematous skin irritation. The drug is readily absorbed when applied to intact skin and mucous membranes and can carry substances dissolved in the DMSO or present on the skin into the bloodstream.

The Agency is also concerned about the intravenous administration of DMSO in some "clinics" for arthritis and other ailments.

History

DMSO is a well-known solvent used industrially since the 1940's. Therapeutic interest in DMSO began in 1963. By

late 1965 an estimated 100,000 patients had used the drug, particularly for sprains, bruises, and minor burns. Despite this widespread use there have been no well-controlled studies to establish effectiveness for these indications.

After toxicological studies showed the drug changed the refractive index of the lens of eyes in experimental animals, FDA, in 1965, terminated all clinical research on the drug then being conducted under Investigational New Drug Applications (IND's). The concern was that damage might be done to the eyesight of humans given the drug. A year later this policy was relaxed to permit clinical evaluation of DMSO in several conditions.

In September 1968, FDA published a further revision of its DMSO policy permitting topical application to the skin for not more than 14 days for less serious disabilities, such as acute musculo-skeletal conditions. This was based on a toxicological study in humans that provided no evidence of eye toxicity due to DMSO in humans during short-term topical use.

Additional animal studies however, have demonstrated that prolonged use in animals causes opacities in the lens.

In 1972, FDA asked the National Academy of Sciences (NAS) to review all available information on the effectiveness and toxicity of DMSO to provide an independent judgment on these matters.

NAS concluded that there was inadequate scientific evidence of effectiveness of DMSO in any disease, and that the toxicity potential was sufficiently great to warrant DMSO's remaining an investigational drug.



Interstitial Cystitis and Scleroderma

In 1978, FDA approved the use of DMSO for the treatment of symptoms of interstitial cystitis after controlled studies were reported to the Agency on the effectiveness of DMSO for this condition and after review by an outside advisory committee. In early 1980, on the advice of its Arthritis Advisory Committee, FDA turned down an application for marketing DMSO for the treatment of ulcers of the hands in scleroderma on the grounds that effectiveness had not been shown by adequate and well-controlled trials for this use.

In the most important clinical study reviewed, a study in which nine patients with bilateral ulcers of the fingers were treated on one hand only, patients showed improvement in both the treated and untreated hands, albeit at a somewhat faster rate in the treated hand. The Agency felt that there was not sufficient evidence from controlled investigations to permit approval for marketing, but there was sufficient evidence to merit encouragement of a larger, more definitive study. At the Agency's request, the Cooperative Systemic Studies for Rheumatic Diseases Group, supported by the National Institutes of Health (NIH), is organizing a well-controlled study of the use of DMSO in the treatment of cutaneous ulcers in scleroderma.

Other Diseases Studied

Studies to determine the effectiveness of DMSO are under way for other conditions, including muscle sprains and strains, several urologic conditions, acute spinal cord injury, and stroke.

However, no sponsor is currently undertaking well-controlled studies of DMSO in the treatment of either rheumatoid arthritis or osteoarthritis and there is no application before FDA requesting permission to market DMSO for these conditions.

Effect on Human Vision

Present studies indicate that short-term topical use of DMSO is not associated with an effect on human vision similar to that in animals. Therefore, the Agency is not requiring

monitoring of the eyes in investigational studies in which topical exposure to DMSO is limited to 14 days or less. However, studies are insufficient at this time to determine whether prolonged use in high dose in humans poses a risk of ocular damage.

While DMSO-related eye damage has not been shown to occur in humans, neither has the monitoring of patients in long-term studies been systematic enough to show that such damage is unlikely to occur.

Because of the absence of systematic long-term follow-up data for eye toxicity in sufficient numbers of patients following repeated or chronic use of DMSO, FDA is requesting that ocular examinations continue to be performed during and following prolonged treatment with high doses of DMSO to provide such data.

Advice to Patients

More information needs to be accumulated and analyzed concerning the effectiveness of DMSO in the many conditions for which it has been advocated, and the issue of long-term safety needs to be resolved. Meanwhile, FDA urges physicians to counsel patients against purchasing DMSO of unknown quality and medicating themselves for purposes for which it has not been shown to be effective. Health professionals may also want to advise patients that when used at high doses for long periods, DMSO has not been shown to be without risk of eye injury.

Physicians should be alerted to the adverse effects of DMSO, which can include erythema, nausea, and the potential risk of blurring of vision or other eye problems. DMSO can initiate the liberation of histamine and one case of severe hypersensitivity reaction has been reported after topical administration.

The more common outlets for the industrial solvent solution are hardware stores, mail order houses, and the backs of trucks operating near shopping centers or parking lots. Pharmacists may be approached to distribute DMSO, marked "degreaser solvent." The Agency urges pharmacists to protect consumers by refusing to distribute this product.

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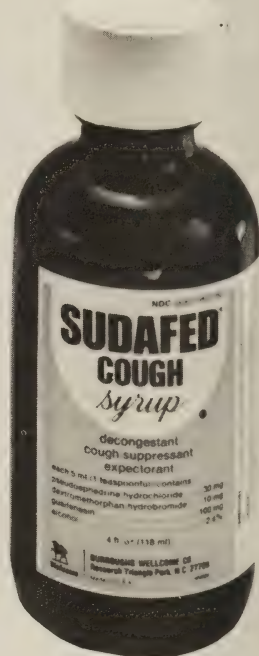
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The Sudafed name and quality...
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Reference: 1. Independent Market Research Audit, 12 month data, Aug. 1980, based on drugstore sales of OTC Sudafed 24's and 100's

*Data on file, Burroughs Wellcome Co.



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Please contact me. I am interested in receiving more information about the Mayer and Steinberg/MPhA Workmen's Compensation Program. ☐ Call ☐ Write.

A Century of American Pharmacy

by
David L. Cowen

continued from February

This series of articles has been contributed by the American Institute of the History of Pharmacy in commemoration of the centennial of the Maryland Pharmaceutical Association. While the centennial is still a year away, the Centennial Celebration Committee is working now to acquaint pharmacists with their professional heritage.

The Economics of Pharmacy

When state associations were being established and when restrictions on who might practice pharmacy were imposed, other changes in the American scene were also profoundly affecting pharmacy. Especially did the growth of big business, particularly both the proprietary and "ethical" drug industries disturb, and then alter, the practice of pharmacy.

First there was the tremendous growth of the proprietary drug industry and the so-called "patent medicines" which they blatantly advertised. Initially the pharmacists attempted to duplicate these remedies with their own concoctions — as early as 1824 the Philadelphia College of Pharmacy had published a *Formulae for the Preparation of Eight Patent Medicines* to guide the pharmacist — but in due course the pharmacist realized that he had to accept the inevitable. He did so only to run into another problem: the competition of the grocer, the department store, the chain store, and the cut-rate druggist.

Price-cutting in American pharmacy went back at least to 1823 but it received its modern start, perhaps, in Pittsburgh where pharmacist George A. Kelly called his four drugstores (trading as Beckham and Kelly) "cut-rate Drugstore" about 1860. One of the "big four" price cutters in the 1880's was Evans of Philadelphia, and such establishments were to be found in New York, Chicago, Cincinnati, Atlanta and elsewhere.

The problem was acute enough to help bring forth the National Wholesale Druggists Association in 1876 and a National Retail Druggists Association in 1883. The latter lasted only four years; the National Association of Retail Druggists came into existence in 1898. A "Campion Plan" calling for

manufacturers to sell only to jobbers (or retailers in some circumstances) who would agree to sell only to retailers who agreed to maintain prices, was tried unsuccessfully between 1883 and 1888, as were a good number of other such plans in that period. A "Tripartite Plan" which brought together the NARD the NWDA, and the Proprietary Association, and which had the blessing of the American Pharmaceutical Association, was declared to be in violation of the Sherman Anti-Trust Act in 1907.

Under the aegis of the NARD, legislation was sought that would put an end to price cutting. States, starting with California in 1931 passed "fair trade" laws that legitimized retail price maintenance. These laws were strengthened by the passage of the Miller-Tydings Act of 1937. (In the meantime there had been some rather mixed experiences with price maintenance under N.R.A. codes.) The legislation came under attack in federal and state courts and received its most severe set-back in the famous *Schwegmann* case decided by the United States Supreme Court in 1951. Slowly the supermarkets, abetted by the consumer movement, and by the Federal Trade Commission, whittled away at the legislation in the courts. Moreover, manufacturers were not finding it to their advantage to prosecute violations of price maintenance agreements. When the "Quality Stabilization Bill" sponsored by the NARD failed to get Presidential support in Washington in 1962, the movement had come to an end.

Price maintenance had in fact run counter to American concepts of free enterprise. American pharmacy was not to enjoy the fruits of price fixing that its European counterpart enjoyed.

Prescription Drugs

Affecting not only the economics of pharmacy but also the professional role of the pharmacist were the changes that took place in the prescription drug field. Industrial expansion, later buttressed by a tremendous scientific explosion, deprived the pharmacist of his birthright. From a compounder and dispenser of drugs he was in danger of becoming a counter and pourer.

The incursion of the industry on the domain of the com-



pounding pharmacist had begun early in the 19th century with the production of the vegetable alkaloids and the halogens. Such drugs as morphine, quinine, iodoform, chloralhydrate, and ethylchloride were not readily made in the rear laboratory of the pharmacy shop. In the post-Civil War period industry began making up galenicals, a class of product that the pharmacist considered within his private domain. But by 1879 Parke Davis & Company was boasting that it had standardized its "Liquid Ergotae Purificans" and industry's ability to turn out products of a uniformity, quality, and efficacy that the pharmacist could not duplicate, persuaded him, despite efforts to hold back the tide, to accept his changing role. In the 1880's G. D. Searle's catalogue was offering no fewer than 450 fluidextracts, 150 elixirs, 100 syrups, 75 powdered extracts, 25 tinctures, and other drug forms for which claims of potency and uniformity were made. Then a new development in chemistry dealt a further blow: the manufacture of synthetic chemicals. The cyclical compounds, carbolic acid, salicyclic acid, phenacetin, and the antipyretics were compounds that the pharmacy shop could produce even less satisfactorily than it could produce veget-

able alkaloids. When the therapeutic revolution of the 1930's burst forth with the introduction of the sulfas, the process was completed: there was little left for the pharmacist to prepare *secundum artem*.

Yet one other difficulty remained to add to the woes of the pharmacist. That was the propensity of the American physician to compound and dispense his own medicines, his right to do so often specifically protected in the state pharmacy statute (as in Pennsylvania in 1887 and Maryland in 1892 and 1898). Moreover, many physicians operated drugstores and state laws sometimes provided for their more or less automatic registration as pharmacist (as North Carolina in 1881). Indeed, pharmacy did not begin to disappear from the curriculum of the medical schools until the beginning of the present century. Slowly, by virtue of the increasing burden on the physician, the improved scientific and professional status of the pharmacist, and the changing nature of the materia medica, the dispensing physician disappeared from the scene, although he lasted generally until the 1930's.



The University of Maryland School of Pharmacy Alumni Banquet was held 51 years ago on May 10, 1930 at the Emerson Hotel in Baltimore.

Perspectives in Pharmacy

Professional Drug Product Selection

Presented
in the interest
of better
informed pharmacy

John C. Wilkie, Jr., R.Ph.
Executive Secretary
Board of Pharmaceutical
Examiners of South
Carolina

"One of the major problems facing pharmacists throughout the country today is the availability of products which have not been approved by FDA. There are drugs on the market with approved New Drug Applications (NDA's) and Abbreviated New Drug Applications (ANDA's). Another group of drugs that was marketed between 1938 and 1962 has been approved for safety but not for efficacy. This group is being reviewed under the Drug Efficacy Study Implementation (DESI) process. A fourth group of drugs marketed prior to 1938 is not subject to premarketing clearance procedures, yet products in this category are marketed every day.



John C. Wilkie, Jr. R.Ph

"Look at the possibility of the pharmacist's liability in dispensing drugs without FDA's approval—the drugs may be improperly formulated, may have formulations causing varied bioavailabilities, may be labeled incorrectly, may cause therapeutic problems, may have adverse reactions, and on and on. In addition, such drugs may be on the market with patent infringements, thus placing the pharmacist in another barrel of

hot water.

"Pharmacists need help — consumers need to rest assured that they are receiving approved drugs, and the medical and pharmacy professions need assurance that all drugs on the market are approved or exempted. Mean-

while, you must know your manufacturer or distributor and, even then, make sure the firm is reliable and responsible."

**Lawrence H. Block,
R.Ph., Ph.D.**
Professor of
Pharmaceutics
Duquesne University
School of Pharmacy

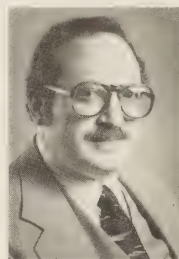
"The scientific aspects of drug product selection have become mired in controversy resulting from the economic or political casting of the issues involved. Product selection by the pharmacist, when permitted by law, ought to result from a consideration of drug product bioequivalence data, the active ingredient, the dosage form, and the drug product manufacturer. However, accurate evaluations of drug product bioequivalence data and the risk of bioequivalence incurred with specific active ingredients

or dosage forms are difficult. Moreover, the FDA's publication of the therapeutically equivalent products list is only an initial step in an effort to document individual product acceptability. The scope of the FDA list is limited; drugs marketed prior to 1938 are not included in the listing. Although these drugs (e.g., methenamine, nitroglycerin, phenobarbital, and thyroid) represent only about 25 percent of the drugs dispensed in the United States, they represent a substantial portion of the drugs available from multiple sources. In addition, the FDA list doesn't reflect manufacturer performance on a batch-to-batch basis. The pharmacist must consider the product manufacturer's potential for replicating a product from batch to batch. A tally of 590 manufacturers involved in approximately 3300 drug product citations in the FDA's weekly reports between 1970 and 1978 refutes the contention that

all pharmaceutical manufacturers maintain equally effective quality-control programs."

Kenneth G. Mehrle, R.Ph.
Past President, National
Association of Retail
Druggists

"The feds and the states want to use drug product selection to cut drug costs—and nothing more—without assuming any liability risks. In state legislature after state legislature, drug product selection proposals



Lawrence H. Block, R.Ph., Ph.D



Kenneth G. Mehrle, R.Ph.

have pitted manufacturers against pharmacy groups, pharmacy groups against consumer organizations, and organized medicine against both pharmacy and consumer groups. Everyone has ended up fighting everyone else. What no one is mentioning is the professional aspect of DPS. That has been irretrievably lost—at least for now.

"In my opinion, true drug product selection is possible only if four conditions exist: (1) The drug industry is reconciled to the idea; (2) the medical profession does not see it as an affront; (3) the FDA stands by every potentially substitutable product and is willing to assume all resulting liabilities; and (4) the pharmacist's professional judgment—and not dollar and cents accountability and the fear of fines and imprisonment—should be the deciding factor in whatever product is dispensed."

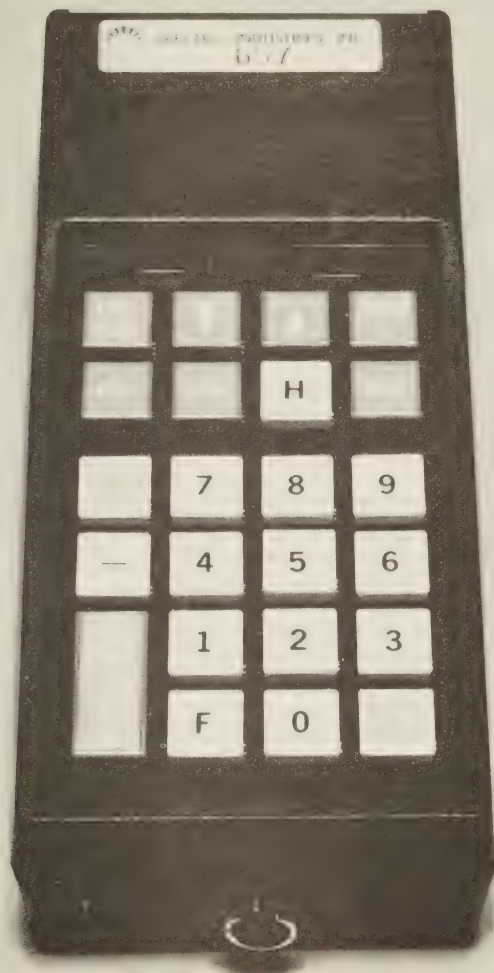


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The views herein are presented as a service to pharmacists and may or may not represent the views of Eli Lilly and Company.

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The New FDA Drug Equivalence List

A Continuing Industry Relations Committee Project

Continued from February issue

We understand that each Maryland Pharmacy will shortly be receiving a copy of the new FDA drug list described below which will be used as the State's Positive Formulary. The following information is presented so that Maryland Pharmacists will be able to effectively use the list in drug product selection.

DRUGS WHICH FDA DOES NOT CONSIDER TO BE THERAPEUTICALLY EQUIVALENT AT THIS TIME ARE CODED "B"

Certain multisource drugs appearing on the List have been classified with a "B" code for a variety of reasons. Those drugs that have been identified by the agency as having potential or actual bioinequivalence problems and for which adequate studies demonstrating the bioequivalence of the particular product have not been submitted to FDA are classified in the "B" category. A "B" evaluation generally is a result of known or potential problems with the specific dosage form for those active ingredients for which no bioequivalence problem has been identified by the agency. In addition, there are currently a few products for which the standards are inadequate or for which FDA has insufficient information at the present time to determine if they are therapeutically equivalent.

The specific coding definitions and policies for the "B" sub-codes are as follows:

BC Controlled Release Tablets, Capsules, and Injectables

These dosage forms are subject to bioavailability and bioequivalence differences, primarily because different firms developing controlled release products for the same active ingredient rarely employ the same approach to formulating their controlled release products. FDA, therefore, does not evaluate different controlled release dosage forms containing the same active ingredient in equal strength as bioequivalent unless equivalence between individual products has been specifically demonstrated through appropriate bioequivalence studies. Controlled release products for which bioequivalence data are available have been coded AB.

DIETHYLPROPION HYDROCHLORIDE

TABLET; ORAL

DIETHYLPROPION HCL

TABLET, CONTROLLED RELEASE; ORAL

TENUATE		
BC	MERRELL-NATIONAL	75MG
TEPANIL TEN-TAB		
BC	RIKER LABS/3M	75MG

BD Active Ingredient and/or Dosage Forms with Documented Bioinequivalence Problems

The BD code denotes products containing active ingredients with known bioinequivalence problems, and for which adequate studies have not been submitted to FDA demonstrating the bioequivalence of the drug products. Where such studies are available, the product has been coded AB.

EXAMPLE

TABLET, ENTERIC COATED; ORAL

AMINOPHYLLINE

BD	RICHLYN LABS	100MG x 200MG
BD	TABLICAPS	100MG
BD	VALE CHEMICAL	100MG x 200MG

BE Enteric Coated Oral Dosage Forms

Drug products in enteric coated dosage forms containing the same active ingredients are subject to significant differences in absorption. In general, such products cannot be considered pharmaceutically equivalent because they do not necessarily meet similar standards, and few manufacturers of enteric coated products have studied the pharmacokinetics of their products. Unless otherwise specifically noted, the agency does not consider different enteric coated products containing the same active ingredients as bioequivalent. If studies have demonstrated the bioequivalence of enteric coated products, such products are coded AB.

EXAMPLE

DIETHYLSTILBESTROL

TABLET, ENTERIC COATED; ORAL

DIETHYLSTILBESTROL

BE	ELI LILLY	100 UGM x 500 UGM x 1MG x 5MG
		250 UGM
BE	ICN PHARMS	5MG
STILBESTROL		
BE	ER SQUIBB & SONS	100 UGM x 500 UGM x 1MG x 5MG
BE	TABLICAPS	500 UGM x 1MG x 5MG

BN Products in Aerosol-Neubulizer Drug Delivery Systems

This code only applies to drug solutions or powders that are marketed only as a component of, or are only compatible with, a specific drug delivery system. There may be significant differences, for example, in the dose of drug and particle size delivered by different products. Therefore, such products are not regarded as pharmaceutically equivalent.

ISOPROTERENOL HYDROCHLORIDE

AEROSOL; INHALATION

ISOPROTERENOL HCL

BN	RIKER LABS/3M	0.25%
ISUPREL		
BN	BREON LABS/STERLING	0.25%
NORISODRINE AEROTROL		
BN	ABBOTT LABS	0.25%

BP Active Ingredients and Dosage Forms with Potential Bioequivalence Issues

FDA's bioequivalence regulations (21 CFR 320.22) contain criteria and procedures for determining whether a specific active ingredient in a specific dosage form has a potential for poor absorption. It is FDA's policy to consider an ingredient meeting these criteria as having a potential bioinequivalence problem even in the absence of positive data demonstrating inequivalence. Pharmaceutically equivalent products containing these ingredients in oral dosage forms are included in this category pending resolution of their bioequivalence or lack of it.

Injectable suspensions containing an active ingredient suspended in an aqueous or oleaginous vehicle have also been included in this sub-category. Injectable suspensions are subject to bioequivalence problems because differences in particle size, polymorphic structure of the suspended active ingredient, or the suspension formulation can significantly affect the rate of release and the rate of absorption. FDA does not consider pharmaceutical equivalents of these products as being bioequivalent without adequate evidence of bioequivalence being presented to the agency.

EXAMPLE DEXAMETHASONE

TABLET; ORAL
HEXADROL
BP ORGANON/AKZONA

BR Suppositories for Systemic Use

The absorption of active ingredients from suppositories that are intended to have a systemic effect (as contrasted with suppositories administered for local effect) can vary significantly from product to product. Therefore, FDA considers pharmaceutically equivalent systemic suppositories as bioequivalent only if positive evidence of bioequivalence is available. In those cases where positive evidence is available, the product is coded *AB*. If such evidence is not available, the products are coded *BR*.

BS Products Having Drug Standard Deficiencies

If the drug standards for an active ingredient in a particular dosage form are found by FDA to be deficient so as to prevent an FDA evaluation of either pharmaceutical or therapeutic equivalence, all drug products containing that active ingredient in that dosage form are coded *BS*. For example, if the standards permit a wide variation in pharmacologically active components of the active ingredient such that pharmaceutical equivalence is in question, all products containing that active ingredient in that dosage form are coded *BS*.

EXAMPLE ESTROGENS, CONJUGATED

TABLET; ORAL
CONJUGATED ESTROGENS

BS	CORD LABS	625 UGM x 1.25MG x 2.5MG
BS	HEATHER DRUG	625 UGM x 1.25MG x 2.5MG
BS	ICN PHARMS	300 UGM x 625 UGM x 1.25MG x 2.5MG
BS	PRIV. FORMULAT.	625 UGM x 1.25MG x 2.5MG
BS	ZENITH LABS	625 UGM x 1.25MG x 2.5MG
	PREMARIN	
BS	AYERST LABS/AMHO	300 UGM x 625 UGM x 1.25MG x 2.5MG

BX Insufficient Data

The code *BX* is assigned to specific drug products for which the agency has insufficient data to determine the therapeutic equivalence status under the policies stated in this document. In these situations the drug products are presumed to be inequivalent until adequate information becomes available to make a full evaluation of therapeutic equivalence.

EXAMPLES ALL PREDNISONONE ALL PREDNISONOLONE

DESCRIPTION OF SPECIAL SITUATIONS

Certain drugs present special situations that deserve a more complete explanation than can be provided by the two-

letter codes in the List. These drugs have particular problems with standards of identity, analytical methodology, or bioequivalence that are in the process of resolution. The following are in this category:

1. **Chlorothiazide Tablets, 500 mg.** — The agency has identified a batch to batch variability problem with currently approved brands of chlorothiazide 500 mg. tableted products. In addition, there is evidence that this tablet dosage form is not proportional in dosage to the 250 mg. tablet. Firms with approved 500 mg. products and FDA are carrying out studies to resolve this matter. These products are coded *BD*.

2. **Conjugated Estrogen and esterified Estrogen Tablets** — Data have been submitted to FDA indicating that there are significant differences in blood levels of the active ingredients produced by different conjugated estrogen tablets. These differences could affect therapeutic activity. They are believed to be directly related to the wide range of differences permitted by the current official standards in the several active estrogenic steroids in conjugated estrogen products. Because of the wide range of the same active estrogenic steroids in esterified estrogens, this same concern extends to these products as well. FDA is working with the USP to revise the standards of identity for conjugated and esterified estrogens. Until such time as the standards issue is resolved, however, FDA is unable to conclude that conjugated estrogen or esterified estrogen tablets produced by different manufacturers are necessarily pharmaceutical equivalents. These products have thus been coded *BS*.

3. **Erythromycin (base) Tablets** — All manufacturers of erythromycin base tableted products demonstrated the bioavailability/bioequivalence of their products as a condition of application approval. At the time of initial approval all such products were tested under fasting conditions and, as a result, all firms were required to label their products to be taken only under fasting conditions. Since that time, at least one firm has substantially revised its product so that it also produces satisfactory blood levels in the presence of food. Thus, the physician and pharmacist must be alert to labeling differences between erythromycin products with respect to administration in the presence of food.

In addition, FDA has received new data which demonstrate the inequivalence of some erythromycin base tablets on a fasting basis. Until this matter is resolved, all erythromycin base tablets have been coded *BX*.

4. **Erythromycin Stearate Tablets** — All manufacturers of erythromycin stearate tableted products demonstrated the bioequivalency of their products as a condition of application approval. These bioequivalence studies were performed under fasting conditions and, as a result, all firms were required to label their products to be taken on an empty stomach. Since that time some firms have demonstrated that their products also may be taken immediately before meals, but not with meals, and still achieve acceptable blood levels. On the basis of such studies, FDA has approved those products to be labeled accordingly. At the same time, the agency stresses that optimal absorption for any erythromycin stearate tablet is achieved when the drug is administered under fasting conditions, and recommends that prescriptions include instructions regarding administration in relation to meals. When erythromycin stearate tablets are to be ad-

ministered under fasting conditions, the agency believes that any listed brand coded *AB* may be considered therapeutically equivalent. If erythromycin stearate is to be taken immediately before meals, only those products with labeling that provides for such administration should be dispensed. Erythromycin stearate tableted products have been designated therapeutically equivalent (*AB*) in the List because all of the products produce equivalent blood levels provided the drug is prescribed and administered in accordance with the conditions for use in the labeling. Prescribers and dispensers are advised to be familiar with the labeling of these products.

5. **Imipramine HCl Tablets** — The agency has determined that certain brands of imipramine tablets may undergo deterioration in their dissolution rate as the tablets age on the shelf, even under normal conditions of storage. FDA will be proposing to the USP a new dissolution rate standard to solve this problem. Those products that already meet the proposed new standard are coded *AB*. Products without data to support satisfactory dissolution are coded *BP*.

6. **Amino Acid and Protein Hydrolysate Injections** — Of these two types of products, only parenteral amino acid mixture solutions presently are listed as approved and marketed under new drug applications. Protein hydrolysate injections are omitted because of safety problems. Because these products differ by the amount and kinds of amino acids they contain, they are not considered pharmaceutical equivalents. Thus, it is on this basis that FDA cannot evaluate these products as therapeutic equivalents. At the same time, the agency believes that it is appropriate to point out that where nitrogen balance is the sole therapeutic objective and individual amino acid content is not a consideration, pharmaceutical alternative products with the same total amount of nitrogen content may be considered as therapeutically equivalent.

7. **Prednisone Tables** — Because of the known bioequivalence and therapeutic inequivalence problems, the USP recently adopted a new *in vitro* dissolution test correlated with *in vivo* bioequivalence data. All products have been subject to a voluntary batch-to-batch certification program over the last year to assure that products are in compliance with the USP dissolution requirement. Based on *in vivo* studies, FDA has published a proposal to establish the USP dissolution requirement as the bioequivalence requirement for prednisone tableted products. Determination of therapeutic equivalence for prednisone tableted products will be made after the evaluation of comments on that proposal. Until then, all prednisone products are coded *BX*.

8. **Prednisolone Tablets** — Although FDA-sponsored biopharmaceutical studies of prednisolone tablets have not revealed product bioequivalence, a determination of the therapeutic equivalence of prednisolone tablets will not be made at present because of the close similarities between prednisolone and prednisone. Based on *in vivo* and *in vitro* studies, FDA has published a proposal to establish the dissolution requirement as the bioequivalence requirement for prednisolone tableted products. As with prednisone, determination of therapeutic equivalence will be made after evaluation of comments on this proposal. Until then, all prednisolone products are coded *BX*.

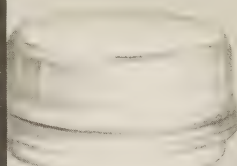
QUINIDINE
SULFATE TABLETS
NDC #0228-2356-10

200 mg. (3 grains)

PUREPAC
FILE CARD

#1

THE INSTANT PRESCRIPTION FROM PUREPAC UNIT-OF-USE



Part #1
Remains
on bottle

Part #2
Attaches
to Rx

Part #3
Product I.D.
(discard)

Lot No.
00000 EXP 0-00

PUREPAC
QUINIDINE SULFATE TABLETS,
USP 200 mg. (3 grains)
Keep container tightly closed.

Lot No.
00000 EXP 0-00

PUREPAC
QUINIDINE SULFATE TABLETS,
USP 200 mg. (3 grains)
See accompanying insert.
Keep container tightly closed.

Lot No.
00000 EXP 0-00

PUREPAC
QUINIDINE SULFATE TABLETS,
USP 200 mg. (3 grains)
See accompanying insert.
Keep container tightly closed.

Lot No.
00000 EXP 0-00

PUREPAC
QUINIDINE SULFATE TABLETS,
USP 200 mg. (3 grains)
See accompanying insert.
Keep container tightly closed.

Lot No.
00000 EXP 0-00

PUREPAC
QUINIDINE SULFATE TABLETS,
USP 200 mg. (3 grains)
See accompanying insert.
Keep container tightly closed.

Lot No.
00000 EXP 0-00

PUREPAC
QUINIDINE SULFATE TABLETS,
USP 200 mg. (3 grains)
See accompanying insert.
Keep container tightly closed.

Lot No.
00000 EXP 0-00

NDC 0228-2356-10

PUREPAC

QUINIDINE
SULFATE
TABLETS, U.S.P.

200 mg. (3 grains)

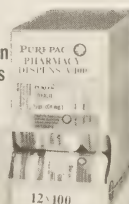
CAUTION: Federal law
prohibits dispensing
without prescription.

100 TABLETS

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- Saves Dispensing Time (No Counting)
- Sealed Unit with Safety Cap
- Package insert outside of package

Also available in 1,000's

Handy 12 bottle
dispensing carton
(Dispens-A-100's
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How Much is Enough?

— A Study of Community Pharmacy Size

The first objective of community pharmacy managers is to provide pharmaceutical services to their patrons. In order to continue to do so, their pharmacies must generate a profit. Profits are needed for working capital requirements, capital improvements, returns to investors, and retained earnings. If stores continually show losses, the capital necessary to sustain normal operations must be borrowed, and interest expenses are incurred that further reduce net profit. Eventually, such a negative cycle results in poor credit and, finally, bankruptcy.

The purpose of this study is to attempt to quantify the impact of store size on selected operating statistics and profitability. The data for the study were submitted by participants in the 1980 *Lilly Digest*.

The accompanying table shows that when floor area increases, total sales volume rises although sales per square foot tend to fall. Prescription sales decrease steadily as a percent of total sales when total sales and floor area are larger which suggests that bigger stores are typically merchandise-oriented operations. As expected, the cost of goods sold increases with total sales and the size of the pharmacy, and this causes a general downward trend in gross margin. The total wage package also has a tendency to decline as a percent of sales in larger stores, whereas rent, except in stores under 1000 square feet (which probably represent more expensive medical building locations), remains relatively constant percentage-wise and contributes to an overall reduction in total expenses. Since gross margin usually drops at a faster rate than do total expenses in larger stores, it is not surprising that net profit declines rather dramatically — from 4.3 to 1.8 percent.

		1980 LILLY DIGEST		
Averages per pharmacy size		Under 1000 sq. ft. (198 Pharmacies)	1000-2000 sq. ft. (420 Pharmacies)	2000-3000 sq. ft. (322 Pharmacies)
Sales				
Prescription		\$ 170,941 — 76.1%	\$ 168,094 — 62.6%	\$ 189,816 — 52.1%
Other		53,663 — 23.9%	100,249 — 37.4%	173,494 — 47.9%
Total		\$ 224,604 — 100.00%	\$ 268,343 — 100.00%	\$ 363,310 — 100.0%
Cost of goods sold		140,166 — 62.4%	170,698 — 63.6%	237,134 — 65.0%
Gross Margin		\$ 84,438 — 37.6%	\$ 97,645 — 36.4%	\$ 126,176 — 35.0%
Expenses				
Proprietor's or manager's salary		\$ 22,371 — 10.0%	\$ 23,087 — 8.6%	\$ 24,869 — 6.8%
Employees' wages		22,049 — 9.8%	28,497 — 10.6%	43,562 — 12.0%
Rent		7,940 — 3.5%	6,610 — 2.5%	7,553 — 2.1%
Miscellaneous operating costs		22,506 — 10.0%	29,313 — 10.9%	37,855 — 10.4%
Total expenses		\$ 74,866 — 33.3%	\$ 87,507 — 32.6%	\$ 113,839 — 31.3%
Inventory in dollars and as a percent of sales				
Prescription		\$ 20,386 — 11.9%	\$ 20,985 — 12.5%	\$ 22,167 — 11.9%
Other		7,366 — 13.7%	20,887 — 20.8%	35,368 — 20.0%
Total		\$ 27,752 — 12.4%	\$ 41,872 — 15.6%	\$ 57,535 — 15.9%
Size of area (sq. ft.)		691	1,417	2,369
Sales per sq. ft.		\$ 325.04	\$ 189.37	\$ 153.36
Rent per sq. ft.		11.49	4.66	3.19
Prescriptions dispensed				
New		12,730 — 53.9%	11,822 — 49.9%	12,370 — 47.7%
Renewed		10,908 — 46.1%	11,859 — 50.1%	13,958 — 52.3%
Total		23,638 — 100.0%	23,681 — 100.0%	26,328 — 100.0%
Prescription charge		\$ 7.23	\$ 7.10	\$ 7.21
Hours per week				
Pharmacy was open		47	52	59
Worked by manager		38	40	42
Worked by employed pharmacist(s)		18	22	33

The ability of management to control inventory investment as well as expenses can make the difference between a profitable and an unprofitable operations. According to the table, prescription inventory is slightly higher dollarwise, as floor area keeps pace with greater prescription volume. However, other inventory expands dramatically with higher sales. The challenge of successful inventory management is to support an expanding level of sales activity with appropriate merchandising space while keeping the investment at a level consistent with adequate customer service.

Sales and rent per square foot of floor area both tend to decline as store size becomes larger. The high rent per square foot in stores under 1000 square feet is characteristic of medical office building locations.

Generally, there is more prescription activity with more floor space. However, the data suggest that pharmacy operations under 2000 square feet are strongly prescription oriented, whereas those over 3000 square feet tend to be more oriented toward merchandising. The prescription charge for stores of various size shows no definitive trend and averages slightly above \$7.00

The hours open per week tend to lengthen with more floor area although stores between 2000 and 5000 square feet in size offer essentially the same number of buying hours per week for their patrons. Since stores over 7000 square feet are highly merchandise oriented, it is not unexpected that they would remain open longest. Employed pharmacist hours usually rise with increasing prescription activity. This is true particularly in larger stores where the manager needs to devote more of his time to the merchandising aspect of his re-

sponsibility and thus requires additional professional assistance to handle a heavier prescription workload.

These data indicate that stores under 2000 square feet are prescription-oriented operations. Those over 3000 square feet in size are more merchandise-oriented pharmacies that show larger sales volume but, percentage-wise, lower net profit levels. It is interesting to note that stores under 1000 square feet in size exhibit all the characteristics of medical office building pharmacies, in which total sales volume is lower, gross margin higher, inventory investment the lowest, and net profit the greatest. Rental expense per square foot is also the highest in such locations. Among the merchandise-oriented stores, those between 5000 and 6000 square feet appear to be generating the highest net profit, which suggests that sales volume and operating costs are optimally balanced.

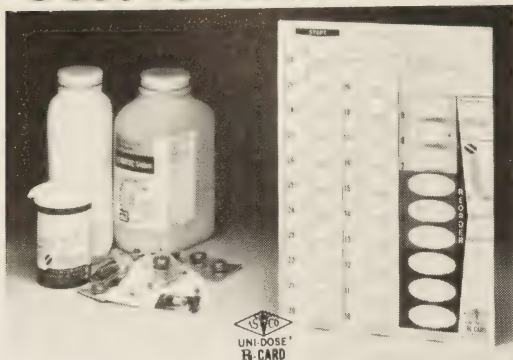
The relationship of floor area to sales volume can be a valuable planning tool for managers of new pharmacies. Once market potential studies are completed, pharmacist-owners can select the floor size that corresponds to the anticipated sales activity and thereby determine operating characteristics. For established businesses, if sales fall short of those shown with comparable floor space, pharmacy owners should consider devoting the excess area to a specialty department, such as a gift shop, or subleasing the space to another tenant. In this way, each square foot can approach full productivity.

To insure the profitability of the business and its long-term success, management must exercise efficient control over all operating costs, particularly as sales volume grows in a larger store.

FLOOR STUDY

0 sq. ft. rmacies)	4000-5000 sq. ft. (108 Pharmacies)	5000-6000 sq. ft. (72 Pharmacies)	6000-7000 sq. ft. (37 Pharmacies)	Over 7000 sq. ft. (42 Pharmacies)
346 — 45.0%	\$ 214,765 — 41.4%	\$ 283,932 — 37.9%	\$ 250,230 — 36.6%	\$ 311,974 — 28.2%
287 — 55.0%	303,479 — 58.6%	465,231 — 62.1%	432,869 — 63.4%	794,206 — 71.8%
333 — 100.0%	\$ 518,244 — 100.0%	\$ 749,163 — 100.0%	\$ 683,099 — 100.0%	\$1,106,180 — 100.0%
377 — 65.3%	348,202 — 67.2%	503,818 — 67.2%	472,786 — 69.2%	764,303 — 69.1%
356 — 34.7%	\$ 170,042 — 32.8%	\$ 245,345 — 32.8%	\$ 210,313 — 30.8%	\$ 341,877 — 30.9%
737 — 6.1%	\$ 26,788 — 5.2%	\$ 32,921 — 4.4%	\$ 29,045 — 4.2%	\$ 35,659 — 3.2%
674 — 13.1%	65,085 — 12.6%	95,963 — 12.8%	85,268 — 12.5%	144,067 — 13.0%
845 — 2.5%	13,934 — 2.7%	17,539 — 2.4%	15,482 — 2.3%	30,044 — 2.7%
346 — 10.5%	52,583 — 10.1%	80,251 — 10.7%	67,579 — 9.9%	112,733 — 10.2%
602 — 32.2%	\$ 158,390 — 30.6%	\$ 226,674 — 30.3%	\$ 197,374 — 28.9%	\$ 322,503 — 29.1%
954 — 2.5%	\$ 11,652 — 2.2%	\$ 18,671 — 2.5%	\$ 12,939 — 1.9%	\$ 19,374 — 1.8%
581 — 11.9%	\$ 25,060 — 11.7%	\$ 29,327 — 10.3%	\$ 25,258 — 10.1%	\$ 33,477 — 10.7%
151 — 21.5%	62,758 — 20.7%	96,029 — 20.6%	79,145 — 18.3%	133,294 — 16.8%
732 — 17.2%	\$ 87,818 — 16.9%	\$ 125,356 — 16.7%	\$ 104,403 — 15.3%	\$ 166,771 — 15.1%
3,308	4,271	5,182	6,203	9,678
99	\$ 121.34	\$ 144.57	\$ 110.12	\$ 114.30
28	3.26	3.38	2.50	3.10
574 — 48.8%	14,576 — 49.2%	19,326 — 50.5%	16,622 — 47.0%	22,004 — 50.7%
248 — 51.2%	15,027 — 50.8%	18,936 — 49.5%	18,730 — 53.0%	21,389 — 49.3%
822 — 100.0%	29,603 — 100.0%	38,262 — 100.0%	35,352 — 100.0%	43,393 — 100.0%
	\$ 7.25	\$ 7.42	\$ 7.08	\$ 7.19
	59	62	59	73
	40	40	34	44
	38	64	48	79

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*U.S. Pharmacist, Sept., 1980, □ Check for reprint.

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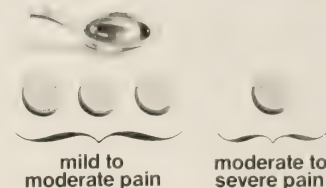
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TYLENOL[®] with Codeine

tablets □ elixir □



mild to moderate pain

moderate to severe pain

Summary of Prescribing Information

Description

Tablets: Contain codeine phosphate*: No. 1—7.5 mg. (½ gr.); No. 2—15 mg. (½ gr.); No. 3—30 mg. (½ gr.); No. 4—60 mg. (1 gr.)—plus acetaminophen 300 mg.

Elixir: Each 5 ml. contains 12 mg. codeine phosphate* plus 120 mg. acetaminophen (alcohol 7%).

*Warning: May be habit forming

Actions: Acetaminophen is an analgesic and antipyretic; codeine an analgesic and antitussive

Contraindications: Hypersensitivity to acetaminophen or codeine

Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.

Usage in pregnancy. Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.

Pediatric use. Safe dosage of this combination has not been established in children below the age of three.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions. Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting, more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.

Dosage and Administration: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. **TYLENOL with Codeine tablets** are given orally. The usual adult dose is: **Tablets** No. 1, No. 2, and No. 3 One or two tablets every four hours as required. **Tablets** No. 4 One tablet every four hours as required. **TYLENOL with Codeine elixir** is given orally. The usual doses are: **Children (3 to 6 years):** 1 teaspoonful (5 ml.) 3 or 4 times daily; **(7 to 12 years):** 2 teaspoonful (10 ml.) 3 or 4 times daily; **(under 3 years):** safe dosage has not been established. **Adults:** 1 tablespoonful (15 ml.) every 4 hours as needed.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings. For information on symptoms/treatment of overdosage, see full prescribing information.

Full directions for use should be read before administering or prescribing.

TYLENOL with Codeine tablets are manufactured by McNeil Laboratories Co., Dorado, Puerto Rico 00646.

Caution: Federal law prohibits dispensing without prescription.

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08721

McNEIL PHARMACEUTICAL
McNEILAB, INC.
Spring House, PA 19477

ALL SHE CAME IN FOR WAS **TYLENOL** with Codeine

Tablets (CIII) contain codeine phosphate 15 mg (1/4 gr). No. 3 30 mg (1/2 gr). No. 4 60 mg (1 gr) plus acetaminophen 300 mg. Elixir (CV): Each 5 ml contains 12 mg codeine phosphate (1/4 gr) and 300 mg acetaminophen. alcohol 7% *Warning: May be habit forming.

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†Based on new and refill prescriptions, 1st quarter 1980

‡Independent market research study 263 stores, June 1980

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Please see brief summary of prescribing information on following page.

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SPRING HOUSE, PA 15477



Dear Dave:

I can identify the year and location of the MphA convention pictured on page 9 of the January, 1981 issue of *The Maryland Pharmacist*. The year was 1901 and the location was outside of the dining hall of Camp Airy in Thurmont, Maryland. If you look carefully, you will see that I have circled my picture in the photograph. As I remember, I was always fond of that panama hat. By the way, the "gang" had a great time at the convention especially when they attempted to capture me and stuff me with crab meat.

Sincerely,
Ross Engel

Editor's Note: Shortly after this letter was sent, the Reagan administration announced that it was suspending the P.P.I. regulations.

Dear Vice President Bush:

The Maryland Pharmaceutical Association is the state professional society of pharmacists in Maryland. We respectfully request that the Administration place a freeze on the regulation of the Food and Drug Administration (21CFR Part 203) (docket no. 79N-0186), "Prescription Drug Products: patient labeling"; known as the Mandatory Patient Package Insert.

The Association supports the concept of providing specific information to the patient concerning prescription and non-prescription drugs. We believe that the health care consuming public is better informed than in previous years and is able to play a more active role in therapy through a better understanding of the treatment. Pharmacists have been a primary source for patient information on prescription and non-prescription drugs for patients over the years and we, therefore, are well aware of the benefits that are available to the public when there is an understanding of the medication. As you are undoubtedly aware, the profession of pharmacy has, in recent years, pressed for greater pharmacist/patient communications so that the trend toward a better informed health care consumer can be increased.

However, we have major reservations about the FDA's approach to patient information. By making the distribution of the patient information mandatory, the FDA has effectively eliminated the pharmacist's professional discretion to allow for interpreting the

needs of the individual patient for specific information. The FDA seems to be saying that the Patient Package Insert will provide the correct information, at the proper level, in understandable language, in a manner that will be readily usable, for absolutely every individual patient that the pharmacist would serve. Our experience differs from this. Certain patients can accept and make use of more detailed information than others. Certain patients are actually intimidated by too much specific information. Many patients are completely apathetic, and the pharmacist may try to involve the patient to improve compliance with the medication. The point is that, these varying situations are now dealt with by the pharmacist on a daily basis. It is a delicate and important aspect of the pharmacist/patient relationship. Yet the FDA presumes that the PPI will suit every patient's requirement for patient information uniformly with absolutely no potential for harm, misunderstanding, or even misinformation. In other ways, the FDA has shown that it values the pharmacist's opinions and abilities as a health care professional, but in this instance, the FDA completely negates the pharmacist's professional capacity in its headlong rush to fulfill a legitimate patient need with a simplistic and massive panacea. We believe there is more potential for harm than good.

Maryland Pharmacists are further concerned that the FDA has apparently completely ignored a major problem confronting pharmacies and other small business. The White House Conference on Small Business identified bureaucratic paperwork as one of the factors that is virtually strangling this vital sector of our economy. Pharmacists are already facing an impossible mountain of paperwork mandated by a labyrinth of federal, state and local regulations. It is choking the life from the small business in this country. Without taking the perspective of the practicing pharmacist's total working environment into account, it may be difficult for the FDA to realize that the PPI will, in many cases, become the final paperwork straw that breaks the camel's back. In short, the average pharmacist does not have room in the pharmacy for the filing cabinet you are mandating.

We do not feel qualified to specifically comment on the FDA's estimates of the cost impact upon the average pharmacist. Our impression is, however, that the FDA has probably underestimated what the ultimate economic impact will be. Pharmacists are now fighting for equitable reimbursement from the third party prescription programs that are increasingly becoming the determinant portion of the average pharmacist's business. These third parties already fail to recognize our substantiated costs of doing business and providing professional services to the public. In Maryland, pharmacists have identified under-reimbursement as the primary problem facing them. Third party programs, including the Medicaid programs, have not kept up with our costs over the years and the setting of reimbursement levels appears to be arbitrary and unrelated to showings of cost by the pharmacist or the Association. The FDA's proposal will raise the cost of each prescription by 6.3¢ by the FDA's own figures. This rise in cost to the pharmacist could not come at a more inopportune time.

We believe it is essential that the pharmacist's professional judgement be given the latitude necessary to make available to the patient individualized information as the need is interpreted by the pharmacist and the patient. We believe that many pharmacists will more willingly cooperate with a voluntary approach to this basic need. Voluntary participation by the pharmacist will allow the vital patient/pharmacist relationship to develop. We urge the FDA to join with the professional associations and the schools of pharmacy in the on-going effort to encourage the pharmacist/patient communications link through educational programs.

Our experience with other government "cure-all" approaches leads us to the conclusion that the FDA's attempt in this area will not be nearly as effective as predicted and may, in fact, cause considerable disruption of the progress now being made by pharmacists.

We appreciate this opportunity to bring to your attention a regulation which we feel most strongly deserves to be reconsidered by this administration.

Sincerely,
David A. Banta
Executive Director



Dr. Ralph Blomster (left) acted as auctioneer at the November Pharmacy auction.



The Auction was held in the basement of the Student Union and a good time was had by everyone who attended.



The money raised at the auction is used to help pay for the 4th year pharmacy class's trip to Eli Lilly.




SAPhA Treasurer Cheryl Betz (right) receives a \$200.00 check from Executive Director David Banta (left). The Association's Board of Trustees had voted to support the expenses for SAPhA's delegate to the APhA Convention in St. Louis.

Pictures courtesy of Paramount Photo Service

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Rx

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Accredited by the American Council on Pharmaceutical Education, each completed unit provides one or two credit hours, depending on the average study time required.

This comprehensive continuing educational program covers a variety of subjects relating to all aspects of hypertension that will provide a broad foundation for the counseling of your hypertensive patron-patients.

For further information on the new continuing education program on hypertension, please contact your CIBA Representative.

AMA DRUG
EVALUATIONS
C I B A

MphA Aruba Trip



The January Aruba Trip was again a popular Association sponsored event. Pictured (left to right) Mrs. David Pearlman, William Pearlman and Mrs. Paul Freiman at a cocktail party hosted by Mayer and Steinberg where they announced their Worker's Compensation Dividend Program.



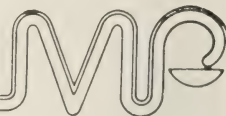
(Left to right) Paul Freiman, Elwin Alpern and Alan Posner soak up the Aruba sunshine.

The Regulatory Flexibility Act

On September 19, 1980 the Regulatory Flexibility Act became federal law. This act is an aid to pharmacies through its effect on small business entities in general. The act attempts to provide "equal treatment of the regulated of approximately the same size" or "equal treatment with due regard for the difference in capacities for the regulated to bear the direct and indirect costs of regulations". The government will inform small business entities that are to be affected by a proposed regulation by ways beyond a Federal Register notice. It will also require an analysis of any proposed regulation. This analysis shall include: demographic impact, economic cost analysis, competitive effects, aggregated impact. This act will attempt to clear up past and proposed regulations that have adversely affected competition, discouraged innovation, restricted productivity, created entry barriers to many industries, discouraged commercialization of inventions, contributed to the steady decline of the small business market share.

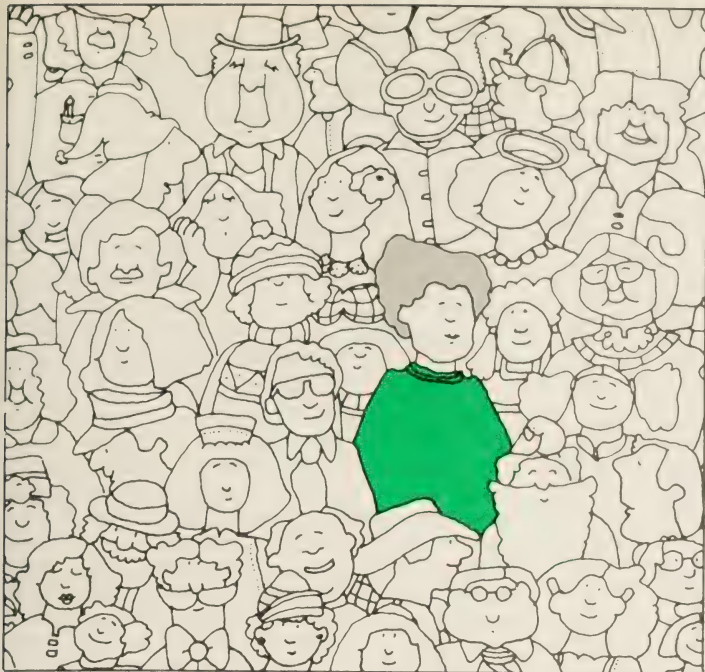
It remains to be seen if the government will carry through on its promises. The most salient pharmacy problems that seem to be affected by this act are the proposed PPI regulations, and the medicaid MAC program. This act is being administered by the Office of Advocacy of the Small Business Administration. Contact that office for further details.

calendar



- MAR. 5 — SAPHa Program — "Computers in Pharmacy", Holiday Inn, Cromwell Bridge
- MAR. 12 — MPhA SPRING REGIONAL — INTERNATIONAL HOTEL, BWI Airport
- MAR. 19 — CECC Program — "Primary Care" — Kelly Memorial Building
- MAR. 22 — AZO Fritz Berman Seminar — "Psychiatry, Neurology and the Pharmacist"
- MAR. 28 — APHa Annual Meeting in St. Louis
- APRIL 30 — CECC Program — "Antibiotics"
- JUNE 19-21 — MSHP Annual Convention — Ocean City
- JUNE 21-25 — MPhA CONVENTION — CAROUSEL, OCEAN CITY
- SEPT. 17-25 — MPhA trip to IRELAND. Further information to follow.

Every Sunday Morning at 6:00 a.m. listen to Charles Spigelmir on WCAO broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore



What Can Your Association Do For You That You Cannot Do Alone?

PLENTY

Pharmacist should stick to the Maryland Pharmaceutical like a bunch of bananas. If you leave the bunch you may just get peeled. The Association is like the heartbeat of Pharmacy. It's something you can turn to when you have a complaint. The Association is your voice in Annapolis. The Association is our watchdog in looking out for interest groups that try to downgrade our profession. We all choose pharmacy as our profession. It behooves us as Americans to make the most of our great profession. Members of our association are among the Pharmacy elite. We are the ones who stand out in the crowd — the leaders — not the followers. Whatever you as a member put into the Association, you eventually get out. Whether its business contacts, political pressure, pleasure trips, dinner theatre, C.E. programs, there is something for everyone. For owners, the Association not only takes pride

in the professional aspects of pharmacy but looks after economic strategy on third party insurance groups. For employees — the Association not only gives you input in the Employee-Employer Relations Committee but also is a source to beef up your fringe benefits. The better shape economically the pharmacy or hospital is in, the better chance the employee has for advancement. We shall all be a part of the building blocks of past, present and future pharmacy. Get a friend to join. Volunteer for a committee. Attend a meeting. Testify in Annapolis. Come to a convention. Support your profession. Your professionalism doesn't end when you lock the pharmacy at night. We want you to help the heart beat and to be part of a good bunch of bananas.

Frank Blatt

Call (301) 727-0746 for details

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

CLONIDINE:

The use of clonidine (Catapres) has been associated with the occasional development of hyperglycemia. Original studies suggested this alteration in plasma glucose was mediated via a mechanism involving the release of growth hormone from the pituitary gland. Subsequent work refutes this hypothesis but does not offer a suggestion as to how this alpha-adrenergic stimulant causes the observed hyperglycemia. *J PHARM EXP*, Vol. 214, #2, p. 433, 1980.

ANGINA:

Patients with angina who smoked at least 10 cigarettes per day were given propranolol and their response to the drug therapy compared to the identical therapy applied to non-smokers. The authors have concluded that cigarette smoking alters hemodynamic parameters and thus is capable of interfering with the beneficial effect of the beta-adrenergic blocking agents. *BR MED J*, Vol. 281, #6234, p. 191, 1980.

QUINIDINE-DIGITOXIN:

A significant interaction has been noted to occur when digoxin and quinidine are administered concomitantly. The reaction tends to increase digoxin levels and thus increases the likelihood of digitalis toxicity. Digitoxin is used occasionally when a cardiac glycoside is indicated so an experiment was designed to assess the possibility that it would interact with quinidine in a manner similar to that observed with digoxin. Ten healthy volunteers were given both drugs, but investigators found no interaction to occur and feel it is safe to use quinidine and digitoxin together. *N ENG J MED*, Vol. 303, #12, p. 672, 1980.

HIGH DENSITY LIPOPROTEINS:

Elevated levels of high-density lipoproteins, as seen in trained athletes, have been associated with a reduction in the incidence of coronary heart disease. Ingestion of moderate amounts of ethanol will also produce this type of effect. A study was conducted in a group of marathon runners to determine the concentration of high-density lipoprotein in their plasma. A questionnaire was also supplied to obtain information about their alcohol consumption habits. Although no runner drank excessively, those who consumed moderate amounts of ethanol had a higher concentration of the beneficial lipoprotein than did those who never or rarely drank ethanol. The authors do not advocate alcohol ingestion as a way to increase levels of high-density lipoproteins. *N ENG J MED*, Vol. 303, #20, p. 1159, 1980.

WEIGHT LOSS:

Many drugs have the ability to increase or decrease body weight. Animal experiments utilizing high doses of benzodiazepine derivatives have indicated that the minor tranquilizers will increase body weight. A study conducted for five months in human volunteers receiving average doses of these drugs show that actually body weight will tend to decrease somewhat. The weight loss is thought to be due to a decrease in muscle mass rather than to a reduction in the content of body fat. *BR MED J*, Vol. 281, #6247, p. 1039, 1980.

ACUPUNCTURE:

Patients with recurrent pain were subjected to low-frequency electroacupuncture techniques. Basal levels of beta endorphin in cerebral spinal fluid were determined before and after the treatment. The level of this hormone increased in all subjects receiving the therapy and thus investigators have postulated that a portion of the analgesic activity provided by electroacupuncture is due to the release of this substance from the cells of the central nervous system. *LANCET*, Vol. II, #8201, p. 946, 1980.

CHLORAMPHENICOL:

Ampicillin has been used to treat meningitis caused by *Hemophilus influenzae*, but resistance is developing to the drug. Chloramphenicol (Chloromycetin) has been reserved as an alternate, but now its usage is increasing. Since injected drug therapy generally costs more to administer and is more painful to the patient than drugs taken orally, a group of clinicians have utilized chloramphenicol in oral dosage forms and found the drug to be as effective as when the drug is administered intravenously. The old adage that oral administration of chloramphenicol causes more side effects, especially aplastic anemia, seems not to be true. *J AM MED A*, Vol. 244, #17, p. 1883, 1980.

METHICILLIN-RESISTANT STAPH:

Methicillin (Staphicillin) was the first semi-synthetic penicillin used to treat infections caused by resistant *Staphylococcus aureus*. Shortly thereafter, reports of organisms resistant to this antibiotic were published, but not an outbreak has been reported in a university hospital. Vancomycin was found to be the most effective antibiotic for eradicating the infection. *ANN INT MED*, Vol. 93, #4, p. 526, 1980.

OXAZEPAM:

The clearance of oxazepam (Serax) was measured in a group of healthy males and females aged 22 years through 84 years of age. In the group of 38 volunteers, it was noted that the clearance of the drug occurred less rapidly in women than in men, and generally decreased with age. Smoking apparently increased the rate at which the drug was removed from the plasma independent of other factors including age and sex. *J PHARM EXP*, Vol. 215, #1, p. 86, 1980.

HIRSUTISM:

The excessive growth of facial hair in women has been treated with mechanical methods such as shaving or using a depilatory. These methods are often unacceptable to the patient so drug therapy has been examined as a way to control the problem. It appears as if there is one drug that can reverse the androgenic influences without causing serious side effects. The drug found to be effective in some of these situations is cimetidine (Tagamet). Initial responses indicate that the drug may offer a safe and effective way to treat androgenic-dependent hirsutism but not without significant expense. *N ENG J MED*, Vol. 303, #18, p. 1042, 1980.

CAPTOPRIL:

The inhibition of the synthesis of angiotension II, as accomplished by the administration of captopril, produces a reduction in blood pressure during the initial period of treatment. However, other mechanisms have been proposed to explain its antihypertensive activity. Recent studies indicate that captopril and thiazide diuretics produce good initial blood pressure control via this mechanism but that long-term reduction of elevated blood pressure is probably due to alterations which are found to occur in the activity in kinins and prostaglandins. *CLIN PHARM*, Vol. 28, #4, p. 499, 1980.

VITAMIN A:

Deficiencies of vitamin A can cause cell dedifferentiation and metaplasia in epithelial tissue and enhance the susceptibility of animals to neoplastic growth. Some evidence has indicated that humans may be more likely to develop cancer if vitamin A levels are suppressed. A prospective study utilizing serum samples obtained from approximately 16,000 men helps support this hypothesis. Serum samples were stored until a report was received that the patient had documented neoplastic growth. In all, 86 men developed cancer and their plasma samples were tested to determine if there was a difference in the content of retinol in their plasma as compared to that of controls. Results indicated that the group of men who developed cancer had significantly lower levels of serum retinol than did controls and thus the authors of this article have suggested that Vitamin A may be useful in reducing the risk of cancer in man. *LANCET*, Vol. II, #8199, p. 813, 1980.

RADIOACTIVE IODINE OVERDOSES:

In rare instances, excessive doses of radioactive iodine have been reported. If the substance is allowed to concentrate in the thyroid gland, there is an increased likelihood that there will be abnormal activity in the thyroid gland which may develop into benign or malignant thyroid nodules, especially in children. In order to suppress salt. It was noted that a single dose of 30 mg. of stable iodide will markedly suppress the uptake of radiolabeled substance and suppression can be maintained with as little as 15 mg. of the stable iodide salt per day. *N ENG J MED*, Vol. 303, #19, p. 1083, 1980.

METHOTREXATE:

Children with acute lymphoblastic leukemia are often maintained on oral methotrexate therapy. Since the drug seems to be more effective in some children than in others, the rate of absorption of the drug was measured in the presence and absence of food. The absorption of methotrexate was found to be retarded when it was taken in the presence of food. Some clinicians feel that the reappearance of the acute phase of the disease may be seen more frequently in children who take their medication with meals than in those who take it on an empty stomach. *LANCET*, Vol. II, #8201, p. 944, 1980.

FAT ABSORPTION:

The ability of the body to absorb foods is partially determined by the size of the food particle ingested. Volunteers were given equivalent amounts of peanut oil, peanut butter and whole peanuts and were asked to remain on a vegetarian

diet for the duration of the experiment. The only fat ingested was to be the peanut products. It was not that fecal excretion of fat was greatly increased in those who ingested the peanuts while it was lowest in the group who consumed the fat as peanut oil. Chewing food seems to enhance the benefit derived from peanuts and presumably from other foods as well. *N ENG J MED*, Vol. 303, #6, p. 917, 1980.

VERAPAMIL:

Much interest has been expressed with respect to utilization of agents which block the calcium-dependent channels responsible for the slow current response. Verapamil is one such agent and it has been used to treat cardiac arrhythmias and coronary spasm. In a double-blind study, verapamil converted 15 of 19 patients with arrhythmias to sinus rhythm while only one of the 16 patients receiving a placebo preparation responded. The drug was used by the intravenous route, but clinicians warn that it should be avoided in patients with the Wolff-Parkinson-White Syndrome associated with a propensity to develop atrial flutter or fibrillation. *ANN INT MED*, Vol. Vol. 93, #5, p. 682, 1980.

ZINC:

Zinc has been used to promote healing of dermatological lesions in patients deficient in zinc. When a trace element is found to be useful in some circumstances, a group of conscientious people often feel they must increase their intake of the ion. Studies conducted in 12 healthy adult males indicate that ingestion of 440/mg. of zinc per day will cause a drop in the concentration of high density lipoprotein by approximately 25%. Since the high density lipoprotein seems to protect against atherosclerosis, investigators have suggested that excessive zinc ingestion be avoided because it may actually act adversely. *J AM MED A*, Vol. 244, #17, p. 1960, 1980.

GENTAMICIN-TOBRAMYCIN:

Approximately 3.2 million people are given aminoglycoside antibiotic therapy each year at a cost of over \$100 million. These agents seem to constitute the most effective group of drugs available to treat the deadly Pseudomonas-induced infections so their popularity is probably due to necessity. Gentamicin (Garamycin) has been used for over a decade but recent evidence seems to indicate that tobramycin (Nebcin) has less potential to produce nephrotoxicity. A prospective study has shown that serious renal complications occur three times more frequently in patients given gentamicin than in those receiving tobramycin. Likewise, the washout time from the kidney is as long as 30 days in the case of gentamicin while it is only 11 days for tobramycin. *J AM MED A*, Vol. 244, #16, p. 1808, 1980.

NIFEDIPINE AND PROPRANOLOL:

Patients with angina were given either nifedipine or propranolol or a combination of both drugs to determine which regimen would be most effective. Analysis of data obtained from 16 patients with severe exertional angina showed the combination to be superior to the use of the individual drug entities. The combination was felt to be both safe and effective for treating this condition. *BR MED J*, Vol. 1281, #6234, p. 184, 1980.



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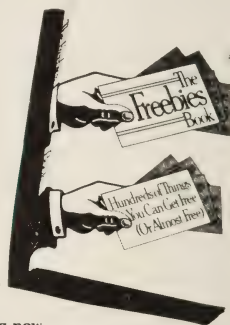
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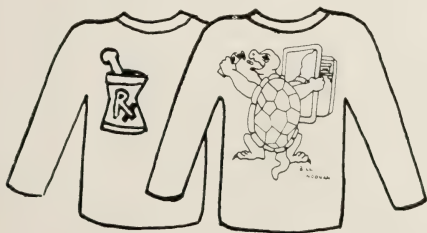
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An MPhA member suggests that pharmacists use this brief form as a way to notify patients of a quantity reduction due to third party limitations. The printing expense is minimal but the public relations benefit is great.

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In most cases we will be able to give you more refills to come up to total quantity ordered.

Please check with us if any question.

Pharmacy

The MPhA Centennial Committee is seeking leads on novelty items and sources for them. Please send your ideas about what you could use during 1982 to promote pharmacy, the 100 years of MPhA and your own business. The Committee is obtaining quotes on sets of glasses with pharmacy symbols, plates, calendars and similar gifts. More ideas will help.

Gentleman owning a 90 year old pharmacy in the Butcher Hill area seeking registered pharmacist as partner. Contact Mr. Sheldon Rosoff at 655-7296 or leave message at 833-2080.

Any Pharmacy having sulfa thalidine (discontinued by MSD) please contact Frank Tamberino at Highland Pharmacy 327-8712. Urgently needed for Patient.

The University of Maryland School of Pharmacy is interested in including 4 antique pharmacy fixtures in its new building, planned for completion in 1983. Anyone interested in such an idea is invited to call the Dean's Office, 528-7650.

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Student graduating in class of 1981 seeks employment. Three years pharmacy experience. Educational background in Geriatrics, Community Management, and Computers. Resume and references on request to Box 4, Maryland Pharmaceutical Association Office.

The Professional Designation Study Committee has asked that members contact the Association office with any comments or recommendations regarding the professional designation. See the January, 1981 issue of the *Maryland Pharmacist* for details and watch for future articles on this subject.

The Industry Relations Committee reminds you that it is prepared to act as an Ombudsman for members who have difficulties with any of the manufacturers. Contact the office for details.

We're listening, Baltimore

Managing a small independent chain means I'm dealing every day with all the problems that confront most small businessmen," says Wesley N. Shelton, R.Ph., who owns and operates four pharmacies in Baltimore, Md.

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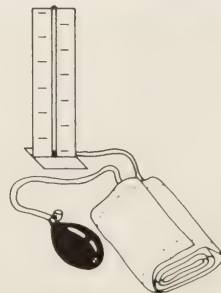
Evaluating Third Party Contracts

— Joseph Fink

Schizophrenia

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My term as President is nearing its end. In addition to the continued expression of thanks to the officers, office staff, committees and students I take this opportunity to thank the membership at large. The individual and collective efforts of the membership are responsible for an active and relatively fruitful year.

The upcoming 99th MPhA Convention will prove to be educational, organizationally active and innovative.

Again, I will remind everyone of the tremendous effort expended by our dynamic Executive Director within the Association, throughout the State of Maryland and nationally. The recognition of the Association and its efforts in behalf of the profession have been expanded through Dave's continued work.

The Board of Trustees and the Association are sorry for the imminent loss of the outstanding efforts of Bonnie Levin. I am sure that we will continue to hear of Bonnie's work as she moves to the West Coast. A friend and professional colleague such as Bonnie will be difficult to replace.

Much remains to be done in our quest for professional and personal recognition. The coming year will be an auspicious completion of a century of existence as an organization.

We must not despair at the seeming lack of recognition by third parties of our members' needs for the equitable reimbursement. Hopefully, the large majority of third party plans will follow suit with Blue Cross in striving for the attainment of more than just adequate reimbursement levels. Most of our members have been providing professional services in spite of the poor and inadequate reimbursement levels and inordinate delays in payment.

A committee is being formed to explore the practicality of having pharmacies operate without stocking Schedule II controlled substances. Those of you having strong opinions pro or con on the subject please contact the Association office to volunteer. The Association would like to present alternatives to the Board of Pharmacy for consideration.

Congratulations are due to Dave Banta for his recent election to the position of Third Vice President in the National Council of State Pharmaceutical Association Executives. The Association was informed of a commendation certificate forthcoming from American Institute of History in Pharmacy.

Thanks to all who represented MPhA at the APhA convention.

Samuel Lickter

EVALUATING THIRD-PARTY PRESCRIPTION PROGRAM CONTRACTS

Joseph L. Fink III, B.S., Pharm. D., J.D.

The third-party prescription drug market is a substantial one for pharmacists in the United States. Depending upon location and composition of the community which the pharmacist serves, a majority of his pharmaceutical services may be provided to patients who do not pay for his services directly.

As the market has expanded, pharmacists have found themselves restricted in their dealings with third-party plan administrators by the federal antitrust laws. The Sherman Antitrust Act of 1890 makes illegal any "contract, combination . . . or conspiracy in the restraint of trade or commerce among the several states. . . ." This statute has been applied to the collective activities of pharmacists when they attempted to disseminate and encourage adoption of uniform pricing schedules.^{2,3}

One observer of these cases noted the result that pharmacists cannot "agree on a pricing policy, they cannot bargain or negotiate collectively for a certain professional fee (or fixed mark-up), and they cannot threaten or in fact impose a collective boycott should they be dissatisfied with a fee being offered."⁴ Whether such a ban on collective action extends to other contractual issues related to the relationship between the third-party plan and the pharmacist is unclear. However, some guidance is available from the Chief of the Special Litigation Section, Antitrust Division, of the U.S. Justice Department, Mr. Lewis Bernstein, who has said:

The antitrust laws do not prohibit discussions between program administrators and pharmacy groups on such topics as methods of reducing administrative burden, management forms, prompt payment.⁵

This view has been shared by another observer who concluded that "pharmacists can collectively negotiate concerning administrative and other non-price aspects of third-party plans. They can inform other pharmacists concerning what took place at the negotiations. They cannot, however, suggest to other pharmacists that they drop out of (or not participate in) a plan because of a failure in negotiations."⁶ (Parenthetical statement added.)

Because pharmacists cannot collectively negotiate reimbursement levels with program

administrators, "the usual pattern is for the program to unilaterally set the dispensing fee, with the pharmacist being given a take-it-or-leave-it option."⁷ Pharmacists tend to accept such offers for three reasons:⁸ the disparity in bargaining power, the feeling that their competitors have accepted or will accept the terms of the agreement, and the likelihood that the number of prescriptions dispensed to patients under the particular program will not be a significant portion of their practice. To assist pharmacists to make informed evaluations of offers to participate in third-party prescription programs, a discussion is presented of some of the issues to consider when reading the proposed contracts.

It should be emphasized at the outset that third-party prescription drug programs involve many types of contracts. The program administrator will enter into a contractual relationship with the sponsor of the group benefits, e.g., an employer or a labor union, and perhaps with a claims processor to handle the paperwork. Contracts also may exist between the program and the individuals for whom benefits are to be provided — the subscribers or beneficiaries. Finally, a contract will exist between the program and the provider, i.e., the pharmacy owner. The last contract shall be the focus of this discussion. Nonetheless, it should be borne in mind that a number of contractual relationships exist in the program which could affect other contracts. For example, should an individual pharmacist desire to increase his professional fee, such a change might not be possible unless the "master" contract with the employer or union is changed. Hence, many of the contracts are interrelated and, in some cases, it may not be possible to negotiate a change in the program-provider contract.

An understanding of some basic aspects of the law of contracts also is necessary for consideration of this topic. For a contract to result, one party must extend an offer and the other party must accept that offer in the exact terms stated. Any variation, however slight, in the terms of acceptance will not result in an agreement. When one varies or omits a term from the acceptance that was contained in the offer, he is making a counteroffer, which must in turn be accepted by the party who originally extended the offer. For example, if a pharmacist were to receive an offer to participate in a third-party plan from the administrator and find the reimbursement scheme unacceptable, he could not merely obliterate the amount contained in the offer and enter an amount acceptable to him. A contract would not result from such an action. In altering the terms of the

original offer, the pharmacist has extended a counteroffer to the plan administrator. This counteroffer must be accepted by the plan before a contract results.

POINTS TO EVALUATE

There are a substantial number of points to evaluate when reading an offer from a third-party plan to participate in its program. The purpose of this article is to provide a discussion of issues to be considered. It will be a rare occasion when all the issues to be discussed will be seen in one contract. Moreover, some of the issues will be relevant only to those offers of participation which originate with government agencies, e.g., Medicaid programs. Nonetheless, pharmacists should be aware of the potential impact of certain contractual provisions on their practices and their legal rights.

Level of Reimbursement. Probably the first provision which attracts the attention of the pharmacist perusing an offer of contract for the first time is the level of reimbursement. Most third-party drug program contracts in the country are administered on the basis of reimbursing the pharmacist for a product cost plus a factor to cover operating expenses and, hopefully, profit, known variously as the "dispensing" fee or "professional" fee.

The pharmacist must evaluate whether the fee, however designated, is within the economically acceptable range. Cost-of-dispensing studies have been conducted in a number of states pursuant to the Medicaid regulations,⁹ and the results of those surveys have been transmitted to the pharmacists who participated. For those who do not have this information available now, the American Pharmaceutical Association soon will be releasing its Uniform Cost Accounting System (UCAS) for pharmacy owners and managers. This service will enable the pharmacist to determine his average cost to dispense a prescription. Using the average cost generated by either means, the pharmacist should compare it with the amount being offered by the third-party plan.

Does this mean that the pharmacist should automatically reject the offer to participate in a third-party program which offers a fee which is less than his average cost to dispense? Certainly not. However, the pharmacist should make an informed decision. For competitive or marketing reasons, the pharmacist may wish to agree to participate in such a program even though the fee provided will not cover his average cost to dispense. Yet he should go into the transaction with his eyes open to the possibility that if prescriptions dispensed to beneficiaries of the plan become a large portion of his practice,

adjustments may have to be made in other operational areas, assuming that his average cost to dispense remains higher than the fee provided.

The fee to be paid should be specified in the contract. A contract recently distributed by a state Medicaid agency promised to reimburse the pharmacist "a fee to be determined by the state."⁹ One who signs such a contract gets what the largess of the state decides, which may not be acceptable to him. Contracts bearing such terminology may be legally unenforceable due to vagueness, i.e., the contract may not specify an important term—level of payment. But who desires to go to the expense of litigating the point, only to have the court find that no valid contract exists? Courts will not imply or add essential terms to a contract for the parties.

Probably as important, if not more important, is a provision in the contract that the reimbursement will be periodically reviewed for adequacy. Adjustments could be based on changes in the consumer price index or on a formula which takes into account a number of factors. The Michigan Pharmacists Association has devised such a formula.¹⁰ Mention of "periodic" review is probably insufficient for the pharmacist's purposes. Who is to determine when a review is needed? The time period should be specified, e.g., yearly. It also is desirable that the contract specify that the results of the review will be implemented and when changes will be effective, e.g., a periodic review to be conducted in March of each year with adjustments effective July 1.

Pharmacists have experienced major problems with lack of speed in the reimbursement process. Indeed, some pharmacists have been placed in such a precarious position by the slowness of program administrators that they have had to secure bank loans or lines of credit to keep their practice viable while awaiting reimbursement. It would be desirable, from the pharmacist's point of view, to have the contract contain a provision that properly executed claims which are not paid within a stated period of time following submission, e.g., 20 business days, would be subject to an interest penalty assessed against the plan. After all, the plan does, in essence, have use of money legally due the pharmacist. Should it not pay for that privilege as the pharmacist must when dealing with his creditors?

Most third-party prescription drug programs are administered on the basis of the pharmacist providing a service to the plan beneficiary and then waiting to be reimbursed. Under an alternative approach, not as frequently seen in prescription drug programs, the beneficiary pays the pharmacist for services rendered and then the beneficiary submits the claim for reimbursement. The advantage to the pharmacist in this approach is that he is paid instantly and the long wait for reimbursement is shifted to the patient. From the plan administrator's viewpoint, this latter approach has the advantage that beneficiaries may not bother to submit claims, resulting in lower program costs. However, this advantage to the administrator is outweighed by the disadvantage of having to deal

directly with so many plan beneficiaries. Moreover, if pharmacists who deal with third-party plan forms daily have trouble properly executing claim forms, imagine how plan beneficiaries would perform. Consequently, plan administrators approach most prescription drug programs from the viewpoint of dealing with the providers, not the patients. An exception to this general rule is patients who have prescription drug coverage under their major medical insurance policies. In those cases, the customary approach is for the patient to pay the pharmacist and submit the claim himself. Some plans operate on either basis, and the pharmacist would be wise to consider asking the patient to pay him and do the paperwork.

Cost-Sharing. An additional issue related to the role of the program beneficiary or enrollee is the existence of some form of cost-sharing. A number of approaches are seen in insurance programs. With copayment, the form most frequently encountered in prescription drug programs, the patient pays a fixed amount per unit of service, e.g., \$2 per prescription. Coinsurance is the approach wherein the patient pays a fixed percentage of the charge per unit of service, e.g., 20% of the prescription charge. Corridor deductibles also are used. Under this approach, the patient pays the first predetermined amount of the expense before insurance plan coverage goes into effect, e.g., the plan beneficiary will pay the first \$100, with the plan paying all expenses above that amount per benefit period.

Copayment is the approach most easily adopted by the pharmacist. The calculations are simple and little additional record keeping, if any, is required. With co-insurance, a separate calculation must be made for each prescription to determine the patient's contribution. When a corridor deductible is used, someone must keep a running total of the amount the patient has spent to date to determine when program coverage goes into effect. Consequently, copayment is the cost-sharing approach most pharmacists would favor.

If a copayment provision is in the contract, one must next inquire whether it is mandatory that the copayment be collected in full. Some contracts mandate this while others do not. In the latter situation, it may be permissible for pharmacists to collect less than the full amount of the copayment, as some pharmacy operators have done to increase their third-party prescription volume. Some third-party plans have taken the position that they cannot mandate collection of the copayment amount since that would violate the federal antitrust laws as a restraint of trade. However, if the plans can mandate that the pharmacist collect no more than the copayment amount, can they also not mandate that the pharmacist collect no less? The point soon may be litigated in New Jersey.¹¹

As just mentioned, some contracts contain a provision which prohibits the pharmacist from collecting any amount from the plan beneficiary other than the amount of copayment, co-insurance, or deductible. There may be situ-

ations in which the pharmacist would be justified in assessing an additional charge to the patient, e.g., long distance telephone calls, after-hours emergency service, or delivery service, but agreeing to such a provision in the contract would prohibit him from doing so.

Record Audit. Third-party plan contracts usually contain a provision for inspection or audit of the pharmacy records. Program administrators favor such provisions, at the least, to raise the specter of accountability, and at the other extreme, actually to authorize such activities. Inspection or audit provisions should specify to what records the plan's agents may have access and on what notice. For example, pharmacists may wish to bar plan agents from reviewing pharmacy operational data unrelated to the pharmacy's participation in the program. In addition, the plan's agents should be required to give the pharmacist reasonable notice of an impending inspection or audit so that the pharmacist may object if the time is inconvenient or take steps to collect the information desired. "Reasonable" notice is the type of term attorneys like to put in contracts; however, to avoid unnecessary disputes concerning what is "reasonable" and what is not, the time period preceding the actual visit should be specified, e.g., 48 or 72 hours notice.

When the pharmacist agrees to charge the plan the lesser amount of either product cost plus the stipulated fee or his usual customary charge to the public, the plan would probably have a right of access to the records of prescriptions dispensed to non-plan participants, i.e., private paying patients, in order to determine what the pharmacist's usual and customary charge really is. This may compromise the confidentiality with which pharmacists treat their patients' records.¹²


Of potentially greater importance to the pharmacist who participates in governmental prescription drug programs is that by agreeing to inclusion of an inspection or audit clause in the contract he may be yielding some of his basic rights as a citizen under the United States Constitution. The Fourth Amendment to the Constitution provides that:

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated . . .¹³

However, because this ban applies only to "unreasonable" searches and seizures, there is a category of "reasonable" searches that may be conducted without a warrant. One type of search in that category is a search conducted pursuant to the consent of the individual whose property is being searched. A pharmacist who agrees to give government agents access to the financial records pertaining to his participation in the government's prescription drug plan is waiving this basic Constitutional protection.

Moreover, if government agents were to find some incriminating evidence during their search, the pharmacist would not be able to fall

(Continued on page 10)



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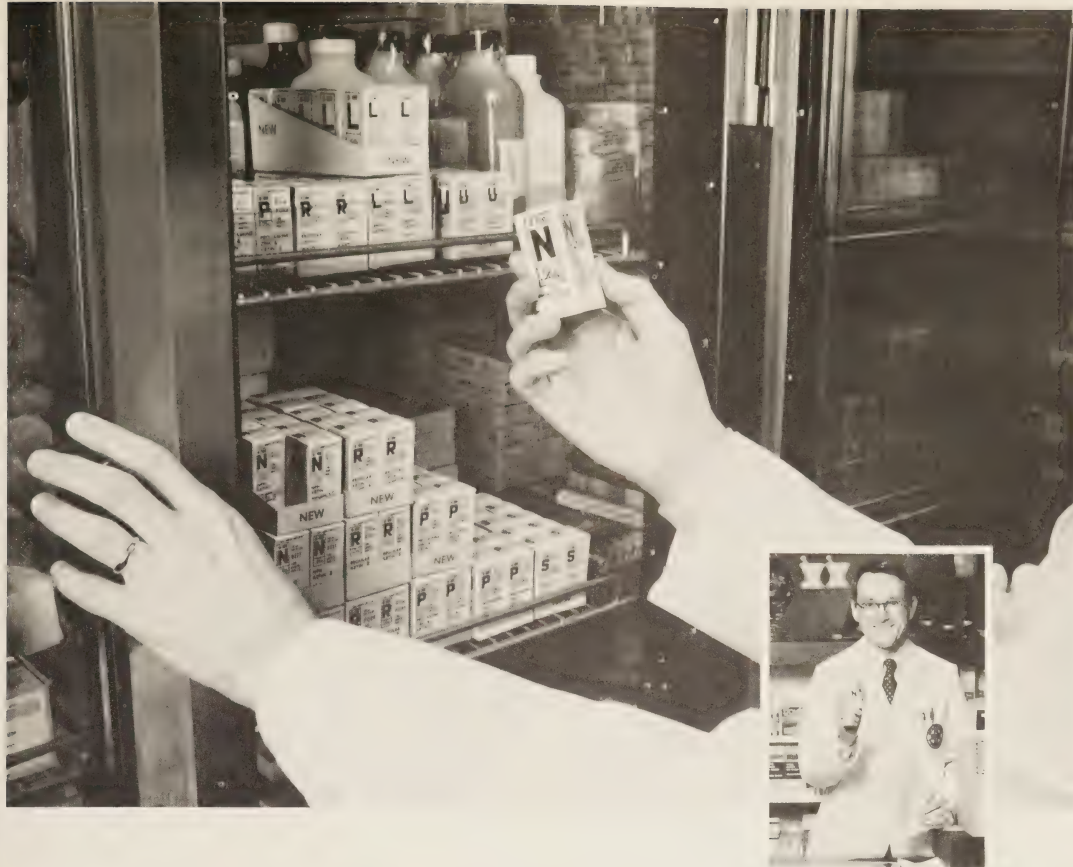
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A Century of American Pharmacy

by
David L. Cowen

Continued from March

The American Drugstore

The American experience in pharmacy has differed from that of continental Europe in more than the matter of price fixing. The limitation of the number of pharmacies has never had any support in American society. Similarly, the ownership and management of drugstores has not been limited to licensed pharmacists in this country. This has made possible the opening of drug departments in department stores, chain stores, and supermarkets. Attempts to legally restrict the ownership of pharmacies to registered pharmacists were negated in 1928 by the United States Supreme Court in a decision involving a Pennsylvania statute that sought to do so. Other devices that sought to meet the challenge of the supermarket — a challenge first, by the sale of over-the-counter preparations and health and beauty aids on a self-service basis and second, by the opening of prescription services within the supermarket — met with similar difficulties. Since the 1940's a tug-of-war on both the legislative and legal fronts has been taking place. The court decision upholding the North Dakota law requiring at least 51% of the controlling interest in pharmacy to be held by pharmacists may generally affect the continuing confrontation. The situation points up the anomalous situation of pharmacy in this country; as a profession contributing to the health of society it nevertheless needs to operate within an economic structure that is basically *laissez-faire*.

These socio-legal realities translate into economic realities. American pharmacy has not been able to afford the luxury of limiting its practice to the handling of pharmaceuticals and closely related medical needs. The American pharmacist, going back to his colonial roots, has always had to supplement his income by devoting a portion of his premises to items bearing little relation to his profession. Glass and paints have given way to notions and sundries and merchandise of all kinds; most uniquely American, however, has been the soda fountain. Pharmacist Elias Durand of Philadelphia operated one of the first soda fountains in an American pharmacy about 1825, and small counter devices became common thereafter. Ornate fountains made their appearance about 1860, and when local and state laws limited the liquor business in the 1880's and national prohibition became a fact in 1919, the soda fountain business flourished.

The fountain, which often expanded into a small restaurant, by 1929 was to be found in three out of every five independent drugstores and in almost all of the chain drug stores. In 1935 drugstores took in \$121 million from their fountains, but thereafter the percentage of drugstores with fountains declined: for independent stores it fell from 58% in 1935 to 46% in 1960 and in chain drugstores from 87% to 67%. The decline was due largely to shortages of soda fountain personnel and material during World War II and the discovery that the space could be used for better advantage in some alternative use.

The soda fountain, be it noted, was responsible for a very significant contribution of American pharmacy to life in the 20th century — the cola soft drinks. Coca Cola was first concocted in an Atlanta, Georgia pharmacy; Pepsi Cola was first concocted in a New Bern, North Carolina pharmacy.

Changing Patterns of Practice

The decline of the soda fountain was an indication that the American drugstore was tending to a greater professionalization. In 1935 it was estimated that only 1% of American pharmacies "seemed to be primarily interested in prescription practice"; in 1962 it was estimated that almost 25% of American pharmacies derived half or more of their income from the prescription department. At the same time there was a tremendous increase in the number and value of the prescriptions dispensed. Whereas some 475 million prescriptions were dispensed in community pharmacies in 1955, over 1,100 million were dispensed in 1971. This reflected both the development of more effective medicaments and the prescribing of single active substances rather than the prescribing of compounds with several ingredients.

The new, potent medicaments, as has already been pointed out, developed and manufactured by the pharmaceutical industry, and ready for dispensing by the pharmacist, virtually abolished the compounding function of the pharmacist. (In countries like Germany the pharmacist does not even have to count. Prescriptions call for pre-packaged quantities only.) In the late 1920's a "broad knowledge of compounding" was still necessary in 80% of prescriptions; by 1940 only 26% of prescriptions required some combination or manipulation of ingredients; after 1971, 1% or less of all prescriptions combined two or more active ingredients.

While the tools of the apothecary were being relegated to the realm of the antique, pharmaceutical practice was being altered by increasing government involvement in public health matters. Commencing with arrangements under Emergency Relief in the 1930's, proceeding through relationships with the Veterans Administration in the 1940's, followed by involvement with Medicaid and Medicare in the 1960's and with various other welfare and related agencies throughout the period, pharmaceutical services came under closer public scrutiny and control. There was a double problem: the possibility that the government might set up its own dispensaries, and the agreement on the basis for and the amount of reimbursement. In any event, the old traditional payment by the patient for services rendered was being replaced, a trend that was carried into the private sector by the development of "third-party payment" plans based on insurance schemes or some form of group employee benefit program that began to make headway in the 1960's.

One interesting development in pharmaceutical practice, and one which may hold a great deal of promise and influence on the future development of the profession, is the burgeoning field of hospital pharmacy. Hospital pharmacy has a tradition that goes back to 1752 and the Pennsylvania Hospital in Philadelphia. Its history is adorned by such figures as Martin I. Wilbert of the German Hospital in Philadelphia and Susan Hayhurst who served as pharmacist in the Women's Hospital of Philadelphia for 33 years at the end of the last and the beginning of the present century. But the great growth in the field, and its establishment as a specialty in pharmacy, began in the 1930's. By 1942 the American Society of Hospital Pharmacists had established itself as an independent organization and by 1957 the country could boast of having 5,833 hospital pharmacists. The hospital pharmacist has moved into a "position of considerable autonomy of professional planning and action," and as a "clinical pharmacist" is participating in the provision of health care through closer contacts with other professional personnel and the patients themselves.

One new facet of the practice of pharmacy on the community level has been the role of the pharmacist as a part of a health team in bringing to the attention of the public matters of significance to public health. On an organized, national

level, there have been the National Pharmacy Week (1924-1972) and the American Pharmaceutical Association's program, begun in 1964, to promote the use of the community pharmacy as "a community health education center." Under such and state association stimulation, the community pharmacy has participated in such activities as blood banks, cancer detection drives, polio vaccine campaigns, venereal disease campaigns, heart disease publicity, diabetes detection, mental illness awareness, and such. The special knowledge of the pharmacist and the special community role of the pharmacy have served the public, and public and quasi-public agencies in the health field well.

The Contemporary Scene

Three major forces have influenced pharmacy in the twentieth century. First was the scientific-technological change, especially rapid in the last generation, that has virtually stripped the pharmacist of the function as a compounder of medicines, changed his educational patterns, and forced him into a new type of service that may become more pharmacological than pharmaceutical. Second was the growth of competition from the supermarket. Not new, except for the heights it reached, it has tended to make the pharmacist more attentive to his professional potentialities. Third was the impact of the new social consciousness. Third-party payments have altered the pharmacist's relations with the patient, have put him face-to-face with government agencies and insurance companies, and have tended to guarantee him a professional fee. The same forces can alter the future patterns of pharmacy in much more radical directions. The old conservative attitudes of resistance will not suffice if pharmacy wishes to master its own destiny. Pharmacy must make its choice between its mercantile and its professional personalities; a choice that may mean disappearance or denigration on the one hand, or a vibrant and significant role in the provision of health care on the other. This is the challenge that the Maryland Pharmaceutical Association faces in its next century.

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This summary, prepared by David L. Cowen, has relied heavily on G. Sonnedecker, *Kremers and Urdang's History of Pharmacy*, 4th ed., Philadelphia, 1976.



PRESCRIPTION PROGRAM

(Continued from page 5)

back on his Constitutional right against self-incrimination found in the Fifth Amendment,¹⁴ for that protection applies only to testimonial evidence, not to physical evidence such as financial records or reports.

Claim Form. An issue which has grown in importance in recent years is what claim form is to be used for submitting data to the program. A substantial number of plans have adopted the Uniform Claim Form developed by the Drug Ad Hoc Third Party Payment System Standardization Committee.¹⁵ While this form has definite advantages over those used previously, it must be purchased by the pharmacist, adding to his operational costs. Perhaps a point of negotiation would be for the pharmacist to suggest that the plan provide the forms, if it has not already indicated a willingness to do so.

Also, does the claim form require the patient's signature? If so, what is the pharmacist to do when one who cannot legally sign calls for the prescription?

The formula to be used for determination of the "cost of drug" factor in the reimbursement scheme can be a critical issue. The difference between use of Average Wholesale Price (AWP) and Actual Acquisition Cost (AAC) has been determined to be approximately 17.5%.¹⁶ In addition, relating back to the discussion of

inspections and audits above, if the program is administered on an AAC basis, the plan would probably demand access to the pharmacist's invoices to verify that it is being charged AAC.

In this age of electronic data processing, problems may result from the data the program administrators feed into the computer. Assume that the pharmacist has dispensed a drug which nearly all pharmacies always buy in bottles of 500 dosage units directly from the manufacturer. However, on this occasion, he ran short and his direct shipment from the firm has not yet arrived. He ordered a bottle of 500 from the local wholesaler to tide him over, paying a much higher price than usual per dosage unit. When he submits a reimbursement claim bearing the higher price, the computer may reject the claim because the acquisition cost is out of line with the product cost limitation programmed into it on the basis of an AAC profile from other pharmacies. At best, his reimbursement will be delayed. At worst, his reimbursement may be deflated to the level which the computer has been programmed to treat as the ceiling AAC for that drug. The pharmacist would then be placed in the position of having to contest the reimbursement, investing time and money to document the claim, or accept a lesser amount than he is actually due.

A related issue is how frequently the plan will update product cost information contained in the computer. Manufacturers have been increasing prices with unprecedented frequency,

and if current data are not in the program's computers, pharmacists may be consistently underreimbursed.

Contract Termination. Consideration should be given to how the contract is terminated. Many third-party contracts are drafted in a fashion to be automatically renewable. This saves the plan the onus of renegotiating the contract periodically. However, automatic renewal may work to the detriment of the pharmacist. Should the pharmacist be working under a contract for which the fee has not been increased for some time, his only option would be to terminate the contract. There is a certain stigma associated with such action that pharmacists seem to find objectionable. Perhaps they do not wish to appear to their patients to be avaricious. However, one cannot suffer long with inadequate reimbursement before operational adjustments will be needed.

Third-party contracts which are not automatically renewable avoid this situation by requiring periodic renegotiation. This provides the adversely affected pharmacist an opportunity to adjust the agreement to a more beneficial arrangement.

In addition to automatic renewal or termination, third-party program contracts usually contain a provision for termination upon notice by either party, with a time period specified following notice during which the contract will remain in force. By agreeing to such a provision in the contract, the pharmacist places himself in

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a position in which he cannot simply stop providing services to plan beneficiaries without giving notice. He has agreed to give 30 days notice, or whatever the contractual provision was, and he must do so. He may not summarily withdraw from the program. On the other hand, these contracts sometimes bear a statement that a pharmacy may be summarily dropped from the program due to abuse or violation of the terms of the contract.

Beneficiary Identification. Turning to beneficiary identification, the plan usually agrees to provide the eligible patient with some form of identification. The type used may be of importance to the pharmacist for several reasons. First, if a paper identification card is issued, the pharmacist or his employee must transcribe the patient's identification number from the card to the claim form. Any time manual transcription is used, the possibility of a transcription error is introduced. If plastic embossed cards are issued to plan beneficiaries, an imprinter may be used to transfer the patient's identification number to the claim form, eliminating the possibility of a transcription error. However, if a plan will be using an embossed card, must the pharmacist purchase an imprinter for use with that specific program's beneficiaries, e.g., bearing a plate with the pharmacy's provider account number? If so, this is an additional expense of participation which the pharmacist will have to evaluate.

If the pharmacist is dealing with an administrator of a large third-party drug program, he may be asked to accept all groups of beneficiaries which the program may enroll in the future. This creates a potential for problems for as new groups are added, each may have an idiosyncrasy to its coverage or administration, creating problems for the pharmacist who must deal with a variety of plans, each with its own peculiarities. If the program enrolls an additional group for a lesser fee per prescription basis, will the pharmacist be contractually bound to accept that lower fee for services provided to patients in the new group?

Exclusions of Coverage. An example of the idiosyncrasies which may be encountered from one group to another is the exclusions of coverage provisions in various program-beneficiary group contracts. Contracts often will exclude from coverage all nonprescription medications, with the exception of insulin, as well as contraceptives. However, one beneficiary group may wish to have OTC's covered while the majority do not, and the same may be true for contraceptives. This can result in a patchwork quilt of plan coverages for the pharmacist who provides service to enrollees in a number of different beneficiary groups.

Devices also are usually excluded from coverage. Nonetheless, consideration should be given to whether the program will pay for federal legend devices, e.g., certain catheters, or devices which are restricted to prescription distribution by state law, e.g., needles and syringes.

Often vitamins are not covered, but what about federal legend vitamin preparations? Are they compensable or not? Some plans also

exclude coverage for drugs used used for treatment of drug addiction or alcoholism. This may result in an anomalous situation when a pharmacist normally would be reimbursed for dispensing diazepam, but because the patient was being treated for alcoholism with the agent he would not be.

The contract also may include some limitations on coverage. Some plans limit the quantity of medication dispensed to a 34-day supply, except in the case of maintenance drugs for which a 100 dosage unit limit may be imposed. Some contracts specify a minimum quantity for maintenance drugs. There is a potential for adverse economic impact in such cases. As large numbers of dosage units of maintenance drugs are dispensed per visit to the pharmacy, the patient will be returning less frequently, resulting in the pharmacist collecting a fee less often.¹⁷

A time limit on refills also may be included in the contract, e.g., a maximum of one year.

Other Provisions. Third-party plan contracts usually include a provision stating that the plan will not be liable for any acts of negligence or other forms of malpractice committed by the pharmacist. Moreover, these contracts often specify that it is the pharmacist's responsibility to obtain adequate liability insurance protection. The pharmacist should be aware of these obligations.

Contracts should provide specific recognition of the pharmacist's right and responsibility to refuse to dispense medication when, in his professional judgment, to do so would be detrimental to the patient. Inclusion of this recognition in the contract may forestall a later dispute.

An "exclusive participation" clause may be seen in some contracts, especially with HMO's. This is a provision that the pharmacy will enter into a third-party agreement with only that particular plan or program. HMO's use it to gain a competitive advantage, and it may well represent an unreasonable restraint of trade on their part. However, the point has not yet been litigated. The pharmacist should seek to preserve his freedom to contract with other programs if he desires to do so.

Related to the issue of participation in other plans is a development of rather recent origin. Some third-party plan contracts include a clause which states:

In the event the participating pharmacy has entered into or enters into contracts or agreements with any other prepaid prescription drug program, then in no event will the plan be required to pay a higher dispensing fee or similar charge however denominated than the dispensing fee being paid by such other program.

Pharmacists should be wary of such clauses. The impact is manifest. One pharmacy operation reportedly is preparing to contest such an approach on the basis that it restrains trade. Plans without this provision in the contract probably would also have grounds to contest use of the clause because it would tend to re-

strain pharmacists from participating in plans which offer fees lower than those paid by the plan using this contractual provision.

Third-party plan contracts also may limit the pharmacist's ability to advertise or otherwise promote the fact that he participates in the plan's program. Often such activities are limited to display of an appropriate decal or sign. This represents a limit on the pharmacist's exercise of his freedom of speech and should be carefully considered.

A clause which frequently is encountered in contracts dealing with many relationships also is often seen in third-party prescription drug program contracts. This is referred to as a merger or integration clause, and it stipulates that all representations or promises made by the parties are contained in the document and that no other promises have been made. Such a statement in the contract would prohibit the pharmacist from attempting to testify at a trial that other promises or contractual terms were to be included in the written document but were not. A rule of evidence also is applicable here. Under the parol evidence rule, spoken words will not be permitted to modify or contradict the terms of a written contract which purports on its face to be complete. Nonetheless, if one of the parties can show fraud, accident, or mistake in the writing of the contract, oral testimony will be permitted to be presented at trial concerning oral statements made before or at the time the contract was made. Note, however, that the burden of proving fraud, accident, or mistake will be on the party attempting to present the oral testimony, and that burden is a heavy one.

With regard to contracts governing a relationship with an HMO, special attention must be directed to the provisions concerning risk-sharing, if this is to be part of the arrangement. The contract should specify how the unexpended balance in the HMO treasury will be distributed to the pharmacist at the end of the year, e.g., on a percentage or prescription volume basis. Of equal importance is the method for determining the amount of the contribution the pharmacist would be required to make in case the HMO revenues do not cover expenses.

Contracts which compensate the pharmacist on a capitation basis should be scrutinized to determine the amount of compensation and time of payment.¹⁸ Naturally, periodic review of the level of capitation reimbursement should be specifically addressed.

A number of legal theories have been suggested for use in attacking the legality of contracts which are unconscionable. The Uniform Commercial Code contains a provision applicable to "unconscionable" contracts:

If the court as a matter of law finds the contract or any clause of the contract to have been unconscionable at the time it was made, the court may refuse to enforce the contract, or it may enforce the remainder of the contract without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.¹⁹

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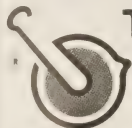


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While this clause has been used most successfully by consumers, it is at least arguably applicable to the relationship between a pharmacist and a third-party drug program.

Unconscionability generally has been recognized to include the absence of meaningful choice on the part of one of the parties, together with contract terms which are unreasonably favorable to the other party.²⁰ Whether these descriptions apply to a given third-party program contract would be a question to explore with legal counsel.

If a pharmacist were falsely told that his competitors already have agreed to participate in the program, he may be able to escape the contractual responsibilities by proving to a court that his agreement to the contract was induced by fraud. However, fraud is difficult to establish because one must typically show that the misstatement or other behavior of the other party was:

1. related to a material matter of fact,
2. made deceitfully with intent to induce reliance,
3. the basis for induced justifiable reliance, and
4. the cause of damages suffered by the first party.²¹ This burden of proof is very difficult to sustain.

The Michigan Pharmacists Association currently is engaged in litigation with Michigan Blue Cross and Michigan Blue Shield over the contract used in those plans' drug programs.²² It is using the rather novel argument that, because of the legal requirement of the antitrust laws, a unilaterally drafted contract should be offered, and because of the dominant position of the Blues in the Michigan marketplace, a monopsony exists which results in the Blues being placed in a fiduciary relationship with the pharmacy operators of the state. If the court agrees that this is so, it may rule, as is hoped by the Association, that the fiduciary relationship requires that the plans be more fair in preparing their contractual offerings than would be expected in normal contracts negotiated at arm's length. It probably will be some time before this case is finally decided by the court.

Finally, some observers have suggested that communicating with the state's insurance commissioner may accomplish some results.²³ Such communication could be legally performed by a group of pharmacists under the Noerr exception to the antitrust laws,²⁴ which affords Constitutional protection to communication with government officials as part of the citizen's right to petition government for redress of grievances.²⁵

CONCLUSION

There are many points to be evaluated when considering whether to participate in a third-party prescription drug program. Some are financial and others are administrative. The pru-

dent pharmacist will carefully review contracts being offered. Not only may they contain the potential for adverse economic impact, but they may infringe on some of his basic legal rights. Only following scrutinization and careful consideration of the contractual provisions will the pharmacist be able to make an informed decision about participation. Such agreements are not the type to be entered into lightly.

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Robert L. Snively, community pharmacist in Georgetown, Delaware, has been named to receive the 1981 Daniel B. Smith Award of the APhA Academy of Pharmacy Practice.

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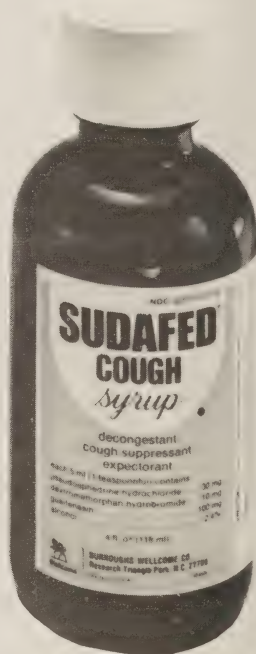
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I.C. System has recognized Ian Turner as one of its top representatives of 1980. Turner represents the MPhA approved collection service in Maryland and the District of Columbia. He was commended for managing a territory that is nationally recognized for producing exceptional collection returns. This is the second consecutive year he has received this honor.



Vernon Trygstad retired as president of the National Pharmaceutical Council on November 13 in Washington, D.C. Trygstad, who had served as NPC President since 1965, received special recognition for his dedication and accomplishments on behalf of the research intensive pharmaceutical industry.



Deborah A. Lasky has been assigned to the Hagerstown territory for The Upjohn Company. She recently completed four weeks of training at The Upjohn Company Learning Center in Kalamazoo, Michigan. Debbie is a graduate of Virginia Polytechnic Institute.



Diane M. Wilson has been assigned to a Baltimore territory for The Upjohn Company. She recently completed four weeks of training at The Upjohn Company Learning Center in Kalamazoo, Michigan. Diane is a graduate of Hampton Institute.



A Pharmacy Financial Management Seminar, sponsored by The Drug House, Inc. and held on February 1, 1981 at the Valley Forge Hilton, Valley Forge, Pa. attracted more than 125 pharmacists and pharmacy students from the Delaware Valley.



Joel Levin (center) Regional Sales Manager of Becton-Dickinson, presents a plaque to (left) Karl Unger, Vice President, Merchandising and (right) William Hensel, Director of Sales, of THE DRUG HOUSE, INC. commemorating the highest percentage increase of sales of all wholesalers, nationwide.

Schizophrenia

Schizophrenia

Schizophrenia

Schizophrenia

Schizophrenia is the most common psychotic disorder. Three symptoms are common to all cases: shallowness of emotional life; inappropriateness of emotion; and unrealistic thinking. Delusions and hallucinations such as the hearing of voices are often symptoms.

Many still refer to the illness simply as "insanity." That term, however, has legal rather than medical significance, connoting a lack of accountability for one's personal conduct.

German psychiatrist Emil Kraepelin in the late 1800s was the first to differentiate this disorder from other psychiatric conditions. He chose the term *dementia praecox*, meaning "early insanity." *Schizophrenia* was coined by Swiss psychiatrist Paul Eugen Bleuler about 70 years ago. It means literally, "splitting of the mind."

A widely-held misconception is that schizophrenia is a "split personality," of the sort displayed by characters in films such as "Sybil" and "The Three Faces of Eve." Actually, these are examples of a rare psychiatric condition known as dissociative disorder. In fact, psychiatrists say that what many schizophrenics demonstrate is more like no personality at all, rather than multiple ones.

I. OCCURRENCE

Schizophrenia is known among all races, cultures and levels of intelligence. It usually occurs first in young adulthood and continues as a long-term disease that results in progressive deterioration of mental faculties.

II. CLASSIFICATION

A. *Basic types.* Although classifications of schizophrenia differ among experts, many psychiatrists recognize three major categories: *disorganized*, *catatonic* and *paranoid*.

- The *disorganized* type (also called hebephrenic type) is characterized by gradual decrease in social and other outside interests and activities in general, and by inappropriate emotional re-

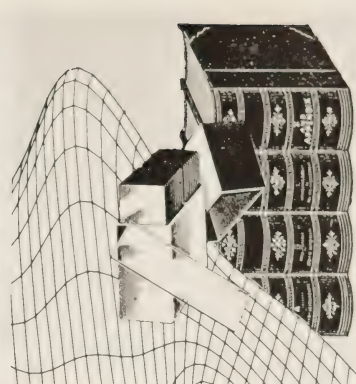
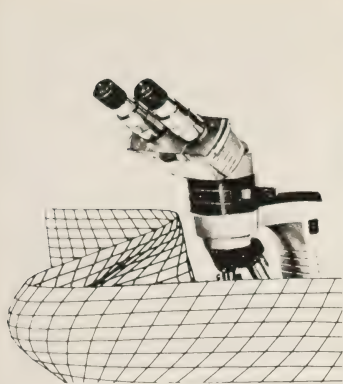
sponses or foolish and bizarre behavior. Grimaces, odd mannerisms and hypochondriacal complaints may also be present, but delusions and hallucinations are not strong features. This illness usually has an insidious and gradual onset and develops into a chronic condition without significant remissions.

- The *catatonic* type is characterized primarily by a disturbance in bodily motion. The patient may remain in a state of almost complete immobility, often assuming statuesque positions (or move to the opposite extreme of rapid and excited motion. In some cases, the patient alternates between the two. Mutism (inability to talk) is common, as is total compliance and absence of almost all voluntary actions. The catatonic type of schizophrenia was common several decades ago, but now is considered rare in North American and Europe.
- The *paranoid* type, which tends to occur later in life, is characterized by delusions of persecution or grandeur, often accompanied by hallucinations. Other symptoms include anxiety, anger, argumentativeness and violence.

B. *Combination of types.* These basic types are not exclusive of one another. A combination of symptoms of different types occurs frequently in the early acute phases, and can also occur in later, chronic phases, when original symptoms sometimes disappear. Schizophrenia that meets the criteria for more than one type is called *undifferentiated*.

C. *Combination with other psychoses.* Symptoms of schizophrenia may be accompanied by symptoms of other mental disorders, notably manic-depressive disorder. Such patients are described as *schizo-affective* types.

III. CAUSES



No clear consensus exists concerning the causes of schizophrenia. Various promising theories, however, are under investigation. More than \$12 million in federal funds is being spent annually on research.

Some experts believe that schizophrenia is really many distinct, separate diseases with causes like those of other diseases such as cancer, heart disease or diabetes. Thus, genetic factors, environmental toxins, viruses, or nutritional deficiencies may cause the illness.

Although little hard data is available, the incidence of schizophrenia seems to vary geographically. Industrial, urban societies show a higher incidence. According to some experts, the greatest proportion of schizophrenia in the U.S. occurs in the Northeast, especially in New England.

Some recent studies suggest that more schizophrenics are born in late winter and spring months than during any other time. The reason is unknown.

Whatever the causes, it is evident that the trend in scientific thinking is away from the once-popular psychoanalytic theory that schizophrenia is caused by such psychic traumas as unresolved anger toward one's mother or by cultural stress. Instead, current research centers on the study of possible biochemical causes. And on this front there is no shortage of theories.

One theory is that the neurotransmitter dopamine, when produced in overabundance, causes schizophrenia. Many neuronal dopamine receptors are located in areas of the brain where thoughts and emotions originate.

Research on animals has shown that the anti-schizophrenic drugs attach to dopamine receptors, blocking dopamine and its effects.

Another theory is that schizophrenia results from the surplus of a normal brain opioid, or the existence of an abnormal one.

This conclusion is drawn from the observation that naturally occurring opioids (or morphine-like substances known as endorphins and enkephalins) can cause catatonia-like states in animals. Also, researchers have noticed that hemodialysis seems to help some schizophrenics, and at least one researcher has identified an abnormal endorphin in dialysis fluid.

Another theory relates schizophrenia to a deficiency of prostaglandin, probably PGE. (Prostaglandins are

hormone-like body chemicals found throughout the body.) Various tests confirm such a deficiency. Schizophrenics are less prone to develop rheumatoid arthritis, a disease characterized by high natural prostaglandin production. Schizophrenics also tend to improve during fever, a time at which brain prostaglandin levels rise.

These biochemical theories of schizophrenia and others may be compatible with each other. Anti-schizophrenic drugs also enhance PGE bio-synthesis, while opioids have been shown to block it.

The latest theory being tested is that a deficiency of serotonin receptors exists in the frontal cortex of schizophrenics. Again, it is feasible that this theory is related with the others in some complex manner.

There is some speculation that schizophrenia may have biochemical causes in 80 percent of known cases, since that is the percentage of schizophrenics who are helped by drugs. Continued research is aimed at developing better drugs through a better understanding of the brain chemistry and processes.

IV. TREATMENT

The development of anti-schizophrenic drugs — specifically chlorpromazine, the first of the "major tranquilizers" — in the 1950s helped empty overcrowded mental hospitals. The ensuing discovery of "minor tranquilizers" — specifically benzodiazepines such as Valium — and antidepressants also played key roles in that drama.

The chief value of chlorpromazine and the class of drugs to which it belongs — phenothiazines — and other classes of anti-schizophrenic drugs, is in preventing disordered thinking and delusions.

Because of the advances in drug therapy, the majority of schizophrenics are treated as hospital outpatients and are able to become productive members of society.

Among the negative aspects of anti-schizophrenic drug treatment are the usual requirements for long-term use and the accompanying side effects. A common, disturbing side effect is tardive dyskinesia (TD), a chronic neurological disorder. TD symptoms include twitching of arms and legs and grotesque, involuntary movements of lips and jaw. The drug L-Dopa is now being used experimentally to relieve those symptoms, and possibly prevent TD.



Dear Dave:

Answer No. 8 to the Jurisprudence Self-Test in the February issue of *The Maryland Pharmacist* is incorrect.

USP standards for freezer temperatures are -20' to -10' C.

The other notations would be more clear if stated as: (-4' to +14' F); and for refrigerator temperatures, 2' to 8' C (36' to 46' F).

I hope the information is correct in the references you used.

By the way, the portions of the federal Controlled Substances Act and the safety container law that apply to pharmacist and physician practices are in USP XX (pages 995-1017 and 1020-1023, respectively) and are kept up to date in the USP supplements.

With best wishes.

William M. Heller
Executive Director, USP

Dear Sir:

For 40 years I conducted a successful Pharmacy at Myrtle Ave. and George St., Balto.; retiring in 1959 because the city required and demanded my property for the Murphy Housing Project.

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Yours Truly,
T. Henderson Kerr, age 93

Mr. Warren Duckett
States Attorney for Anne Arundel County
Annapolis, Maryland 21401
Dear Warren:

As you are aware, I have been primarily involved in the investigation of forged prescriptions and related offenses for the past several years. In each of these years, I have noted increases in both arrests and complaints received. These investigations are somewhat different than other type cases as there is usually no party involved who suffers a loss due to a prescription forgery. The physician usually only suffers the loss of a blank prescription and the pharmacist stands only to gain a fee for filling the prescription.

I have made attempts in the past to create a more cooperative atmosphere between the Police Department and the pharmacists, but have been unable to impact but a handful of them. There are currently sixty-one pharmacies in Anne Arundel County, most of which are independent pharmacies. Independent pharmacies usually are staffed by only the owner/pharmacist. If he is summoned to court he must either close the pharmacy or hire a relief pharma-

cist. If he waits in court all day just to find out the defendant has requested a postponement or a jury trial, he becomes exasperated. Several of the district court judges have been disallowing these postponements but cannot refuse a request for jury trial which is what the defendants have been requesting. We often find out about postponements or prayers for jury trials on the day of the trial. The end result is that pharmacists are becoming increasingly reluctant to report prescription forgeries.

With the increased emphasis on street drugs and the numerous arrests recently made, I can foresee an increase in the diversion to abuse of prescription drugs. I sense certain attitudes and fears among pharmacists that not only emanate from the inadequacies of the Police and Judicial systems, but from the fear of physical harm from persons using forgery, burglary, or robbery to obtain prescription drugs. At this time I am aware of at least two pharmacists who have armed themselves while in their pharmacies.

Pharmacists feel that their problems are not priority with either the Police Department or the Judicial System, so why should they become involved? I am hoping that I can be instrumental in increasing the sensitivity of the Police Department to these problems, but additionally I would like to see the following changes in our court system:

- 1.) Require defendants or defense attorneys to file requests for postponements or jury trials seven days prior to trial.
- 2.) Educate judges and Assistant States Attorneys as to the scope and seriousness of the prescription drug diversion problem.
- 3.) Allow for reimbursement to pharmacists who incur expenses while testifying for the State.

Additionally, I am experiencing an additional problem that you may be able to shed some light on: The problem is in certain drug abusers who will visit as many as ten local physicians and obtain prescriptions for CDS from each of them using either fraud or misled statements. They will then have these prescriptions filled at various pharmacies. It is possible that it would be necessary to summons ten pharmacists and ten physicians to make a case on a subject. This could cause a severe hardship in any particular area of the county and would only aggravate the problems we now have. I am presently conducting several investigations which could end in this manner. I have not brought these cases to a conclusion due to the above stated problems.

I have had some conversation with David Banta, Executive Director of the Maryland Pharmaceutical Association who has concurred that the problems enumerated have and would inhibit pharmacists from getting involved.

I would appreciate your thoughts on these problems and any light you may be able to shed on them. If you need more information or clarification, feel free to contact me. I appreciate your attention in this matter.

Sincerely,
Detective John Santana
Anne Arundel County Police Dept.
Narcotics Unit — Pharmaceutical Section
987-6600, ext. 493



Joseph Loetell, President of the Baltimore Metropolitan Pharmaceutical Association, delivers greetings to the BMPA Annual Banquet held February, 1981.



Past President Ralph Quarles served as Toastmaster for the annual affair which has traditionally been one of the most successful social events in Maryland Pharmacy.



Joseph Loetell (left) presents a plaque to this year's BMPA Honorary President, Abe Bloom, of Paramount Photo Service.



Many Pharmacists attended the February 26, 1981, Continuing Coordinating Council's C.E. program on Geriatrics held at the Convention Center in Baltimore.

Pictures Courtesy Paramount Photo Service



The President of the Maryland Society of Hospital Pharmacists, Patrick Birmingham served as Moderator for the program.

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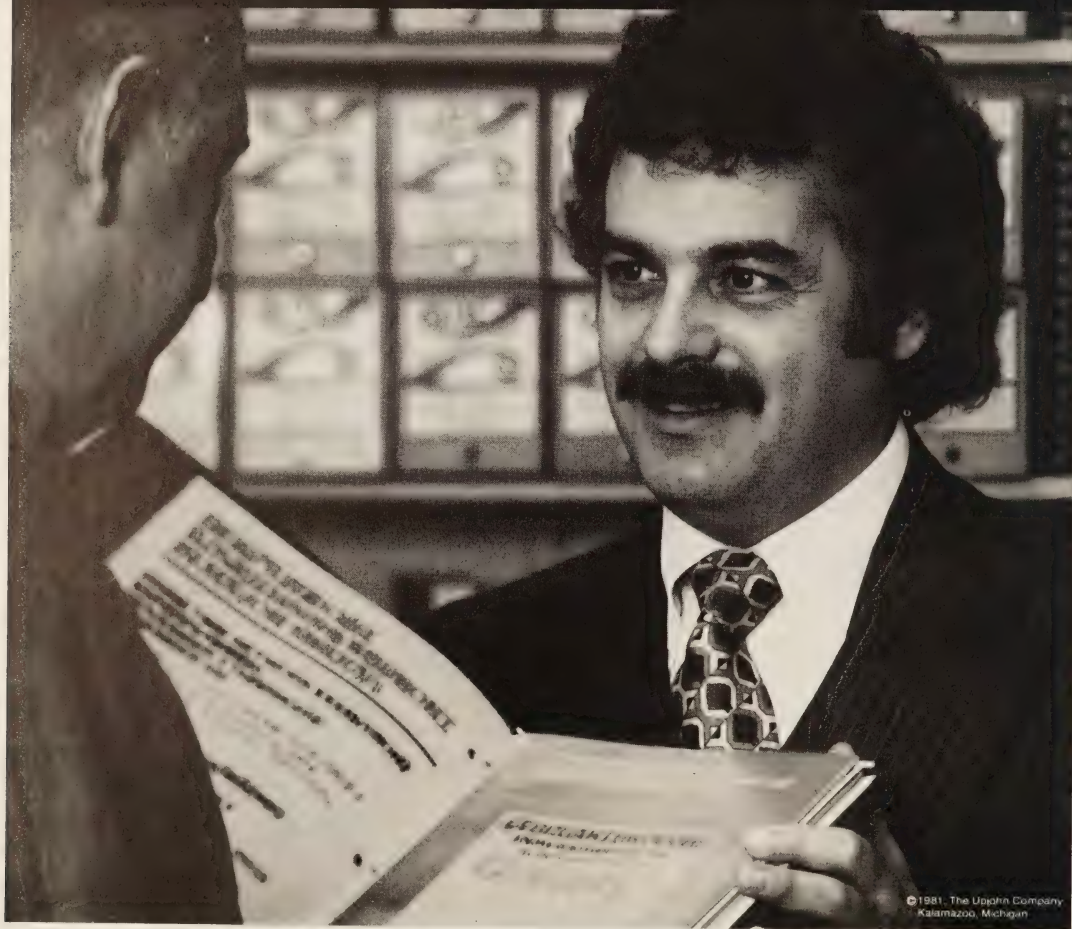
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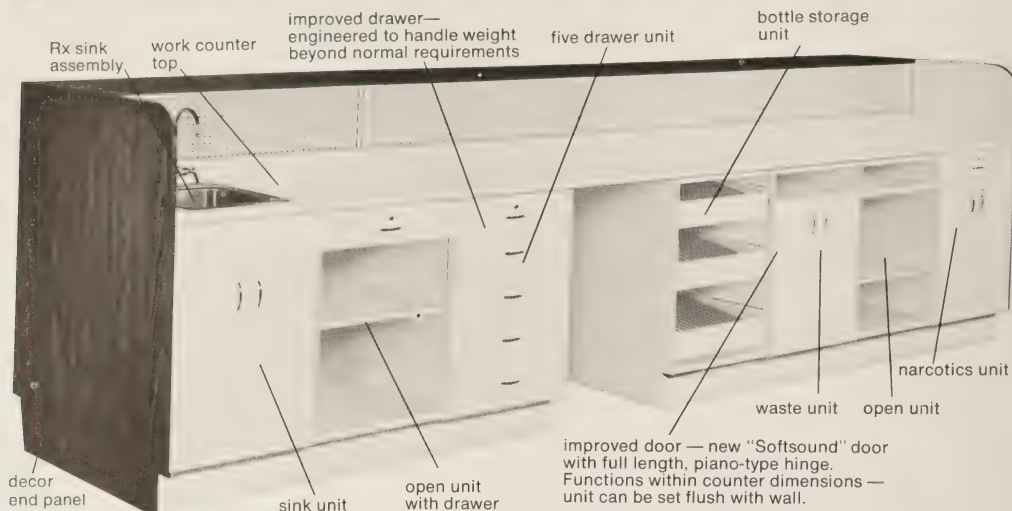
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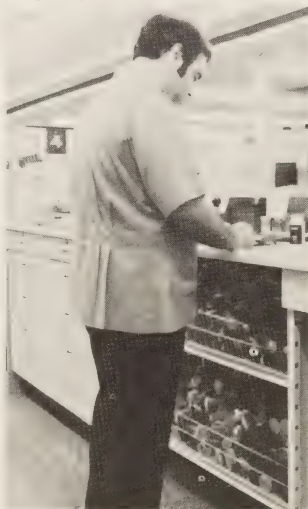
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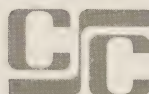
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The Great "P.D." Debate



Ben Franklin came to the MPhA Spring Regional Meeting (disguised as Pharmacy Dean William J. Kinnard) to take the opposing point of view on whether pharmacists should adopt the designation "P.D." with the title of "Doctor of Pharmacy" to replace the traditional "R.Ph."



David Clark, Executive Director of the Indiana Pharmacists Association, presented the proponent point of view at the meeting which was held on March 12, 1981, at the Airport International Hotel in Baltimore.



MPhA President Samuel Lichter (left) and Speaker of the House David Serpick (right) followed the debate with interest.



MPhA Honorary President Victor Morgenroth, who is also Chairman of the Association's Constitution and By-Laws Committee delivered a brief report to the House of Delegates during the Business portion of the Spring Regional Meeting.



MPhA President-elect Philip Cogan (left) presented Karen Disney and Gary Oderda of the Poison Control Center with a check from the Association to support Maryland Poison Prevention Week activities.

Pictures Courtesy of Paramount Photo Service

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

SMALLPOX ERADICATION:

Smallpox was once a dreaded disease throughout the world, but in 1958 the World Health Association requested help in designing and implementing a program which would completely eradicate the disease. In 1966, the program began to make progress and in 1977 the last case of smallpox in the Americas was reported in Brazil. Last year the WHO Global Commission for the Certification of Smallpox eradication concluded that the job had been done and there is no evidence that smallpox will ever return as an endemic disease. *N ENG J MED* Vol. 303, #22 p. 1980, 1980.

CANNABINOIDS AND GLAUCOMA:

The research projects which have investigated the effects of marijuana derivatives on intraocular pressure have produced mixed results, but investigators in Georgia have found that doses which produce a decrease in the pressure also cause significant central nervous system effects. These authors have concluded that marijuana derivatives have no clinical values whatsoever for the glaucoma patient because in order to control intraocular pressure satisfactorily one must stay "stoned" all day. *J AM MED A* Vol. 244, #22, p. 2501, 1980.

DIAZEPAM — ETHANOL INTERACTION:

Ethanol has been found to potentiate the depressant effect associated with diazepam (Valium) administration by enhancing the intestinal absorption of the minor tranquilizer. Further investigation of this phenomenon has indicated that ethanol has still another interaction with diazepam. Results from several controlled studies indicate that potentiation occurred even when the drug was used intravenously. Apparently ethanol has the ability to inhibit the N-desmethyl action of diazepam and increase the half-life of the benzodiazepine derivative. *CLIN PHARM* Vol. 28, #5, p. 638, 1980.

DOXYLAMINE:

After two days of hearings conducted by a committee of the FDA, it has been concluded that doxylamine (Bendectin) does not need to be removed from the market. Although there was insufficient evidence to link doxylamine use with the development of birth defects, the committee has suggested that the drug be labeled to indicate that it should be used only when "clearly needed". *DRUG THER* Vol. 10, #11, p. 39, 1980.

ACNE:

Severe acne responds to drugs such as oral estrogens, steroids, and/or antiandrogenic substances. These drugs produce various side-effects so drugs with fewer toxicities have been investigated. A derivative of vitamin A, 13 cis-retinoic acid, was administered to fourteen patients with severe acne. The serum excretion rate was reduced by 75% at four weeks and all patients experienced at least an 80% im-

provement in their condition. Dose related side-effects included dryness of the skin and mucous membranes. *LAN-CET* Vol. II, #8203, p. 1048, 1980.

MINOXIDIL:

Patients with malignant hypertension may experience a reduction in renal function and a concomitant increase in the mean serum concentration of creatinine. Some patients require dialysis to aid in removal of the metabolic waste products. It was noted that some patients with this condition who were being maintained on minoxidil (Loniten) therapy actually showed an increase in renal function and a significant drop in creatinine concentrations. The authors have suggested that more work be done to determine if this is a widespread action of the drug or just an isolated observation. *ANN INT MED* Vol. 93, #5, p. 676, 1980.

THEOPHYLLINE METABOLISM:

Propranolol (Inderal) has been shown to reduce the clearance of certain drugs metabolized by the hepatic mixed function oxidase system. Studies using propranolol and metoprolol (Lopressor) indicate that the metabolism of theophylline is not altered by metoprolol as it is with propranolol. However, in patients who have increased theophylline metabolism because of their smoking habits, metoprolol will tend to reverse the effect. *CLIN PHARM* Vol. 28, #4, p. 463, 1980.

POVIDONE IODINE:

Povidone iodine is used in various preparations as a topical antiseptic. Several preparations suitable for vaginal use are on the market, so an experiment was designed to determine if the use of these preparations would be associated with an elevation in the plasma concentration of iodide. Patients receiving the medication for treatment of burns have shown elevated levels of the anion, but no data exists to indicate if similar findings occur after vaginal use. In this study, povidone iodine was applied for two minutes and then the tissue was dried. Several samples of plasma showed that there was a significant increase in inorganic iodide. Excessive use of these preparations could theoretically elevate levels of the anion to the point where it could produce hypothyroidism and/or goiter. This is especially true of fetal thyroid tissue and thus the preparations should be used with great caution during pregnancy. *J AM MED A*, Vol. 244, #23, p. 2628, 1980.

DOPAMINE:

Dopamine (Intropin) is used to stimulate the heart, but it has also shown the ability to dilate vessels leading to the kidney and promote formation of urine in compromised patients. Individuals who had experienced early oliguric acute tubular necrosis were given infusions of dopamine to see if urinary function would be increased. The experiments

worked without complications and may represent a more effective way of handling this problem in selected patients. It had been previously postulated that dopaminergic receptors play a role in the regulation of renal blood flow. *LANCET*, Vol. II, #8199, p. 827, 1980.

ZOMEPIRAC:

A new analgesic has been introduced to the United States market which is said to be more effective than aspirin, but is free of addiction liability. Pain relief achieved after oral administration of zomepirac (Zomax) has been found to be superior to that produced by 8 mg. of intramuscular morphine. The drug is a potent prostaglandin inhibitor and will undoubtedly be used extensively for some time to determine its effectiveness in a large group of people. *J AM MED A*, Vol. 244, #20, p. 2298, 1980.

PROPRANOLOL:

Propranolol (Inderal) is a drug with the ability to gain access to the central nervous system and investigators have wondered if a portion of its antihypertensive activity could be due to central mechanisms. Careful investigation has confirmed earlier studies which show the drug can permeate the blood-brain barrier, but these investigators have concluded that the antihypertensive activity of propranolol is due to effects mediated peripherally. *J PHARM EXP*, Vol. 215, #1, p. 221, 1980.

CIMETIDINE AND DRUG METABOLISM:

Cimetidine (Tagamet) has been found to inhibit microsomal drug oxidative function; thus, increasing the effectiveness of drugs such as warfarin (Coumadin), antipyrine, and diazepam (Valium). A structural analog of cimetidine, ranitidine, has been shown to produce no such effect on the metabolism of these compounds and thus it may be preferred to cimetidine in patients taking drugs metabolized by this metabolic pathway. Ranitidine is not yet available in this country. *BR MED J*, Vol. 281, #6243, p. 775, 1980.

ASPIRIN AND CATARACT FORMATION:

A group of researchers have conducted studies in patients who have been taking aspirin for the treatment of osteoarthritis. They are particularly interested in determining the age at which the treated group developed cataracts. Results from the retrospective study indicate that aspirin delayed the onset of cataract formation by approximately 10 years when the treated group compared to a similar group not receiving the salicylate therapy. It has been postulated that salicylate competes with the amino acid tryptophan for binding sites on plasma protein, albumin. Tryptophan is the only amino acid which binds to albumin and thus displacement from the protein until ultimately produce lower concentrations of the amino acid in the plasma. Tryptophan has been known to cause discoloration of the lens of the eye and thus some clinicians feel that the amino acid may actually act as a cataractogenic agent in some individuals. *J AM MED A*, Vol. 244, #23, p. 2593, 1980.

MULTIPLE SCLEROSIS:

A two-year prospective double-blind study has been completed in which the effectiveness of leucocyte extract, named transfer factor, was tested. Sixty patients with multiple sclerosis were involved in the study. One group received

placebo therapy while the others received the transfer factor extract. Investigators noted that the use of the transfer factor reduced the progression of multiple sclerosis, but did not reverse the course of the disease. The effects were most evident after 18 months in patients who had mild to moderate forms of the disease. *LANCET*, Vol. II, #8201, p. 931, 1980.

THERMAL REGULATION:

Body temperature is regulated at least partially via centers housed in the hypothalamus of the brain. It has been suggested that the activity of these centers is mediated via dopaminergic influences. The phenothiazines, drugs such as chlorpromazine (Thorazine), can inhibit dopaminergic activity and can reduce body temperature. More experimental evidence will be accumulated to determine the extent to which dopamine helps in the regulation of body temperature. *J PHARM PHA*, Vol. 32, #19, p. 624, 1980.

BURNS:

During the past 15 years, extensive work has been done in the area of burn care. This has resulted in a significant decrease in the mortality rate associated with all levels of burn involvement. The most notable improvements have been seen in hospitals where a special burn unit is located with special facilities available to treat burned patients. *J AM MED A*, Vol. 244, #18, p. 2074, 1980.

ENDOMETRIAL CANCER:

Various types of cancer are thought to be stimulated by the use of oral contraceptives. A study conducted in almost 5000 women indicates that the likelihood of endometrial cancer is reduced almost by half in women taking these drugs. Women using sequential rather than combination therapy are at a higher risk. The duration of the protection after discontinuation of the therapy is unknown. *N ENG J MED*, Vol. 303, #18, p. 1045, 1980.

NECROTIZING ENCEPHALOMYELOPATHY:

A child with necrotizing encephalomyelopathy or Leigh's syndrome was found to experience symptoms which mimicked the side-effects of narcotic overdose. He often demonstrated periods of apnea and unconsciousness which would be reversed for a short time with the administration of narcotic antagonists. The patient died during an attack and the subsequent autopsy showed endorphin to be present in the brain in high concentrations. Clinicians feel a portion of the symptoms of this syndrome are due to excessive endorphin production by the central nervous system. *N ENG J MED*, Vol. 303, #16, p. 914, 1980.

TRICYCLE ANTIDEPRESSANTS:

The mechanisms of action of the tricyclic antidepressants has been said to involve inhibition in the uptake of norepinephrine by the adrenergic nerve ending. Experimental evidence has indicated that this effect is seen shortly after the administration of the drug, and since it takes several weeks to note the therapeutic effects of these drugs, it has been postulated that other mechanisms may be involved. Recent investigations have shown that the tricyclic antidepressants will inhibit presynaptic alpha receptor activity and thus increase the quantity of norepinephrine released per depolarization wave. This takes a longer time to develop and may represent the major mechanism of action of the tricyclic antidepressants. *J PHARM EXP*, Vol. 215, #1, p. 143, 1980.

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Send your interesting stories about pharmacy in Maryland during 1882-1982 to the Centennial Committee. These can be used as part of the planned, year-long public relations program with local newspapers. When photographs are available please include them with your article. Give us the idea and we will contact you to flesh it out for the public relations program.

Pharmacy space in a medical building coming in late 1981 on Reisterstown Road in Owings Mills (across 1500 units apartment complexes). Suites will be condominiumized for sale or lease. Call evenings 744-0675.

The 16th Annual Maryland Society of Hospital Pharmacists Seminar will be held at the Carousel Hotel in Ocean City, Maryland on June 19, 20 and 21. The theme of this year's seminar will be Communications/Emergency Medicine. For more information please contact Robert Tonelli c/o U.S. Public Health Service Hospital, 3100 Wyman Park Drive, Baltimore, Maryland 21211.

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calendar



APRIL 9 (Thurs.) — MSHP Meeting — Mercy Hospital

APRIL 30 (Thurs.) — CECC Program: "Antibiotics"

MAY 4 (Mon.) — ASHP Regional Conference, Baltimore

MAY 7 (Thurs.) — MPhA Board of Trustees Meeting

JUNE 19-21 — MSHP Annual Convention, Ocean City

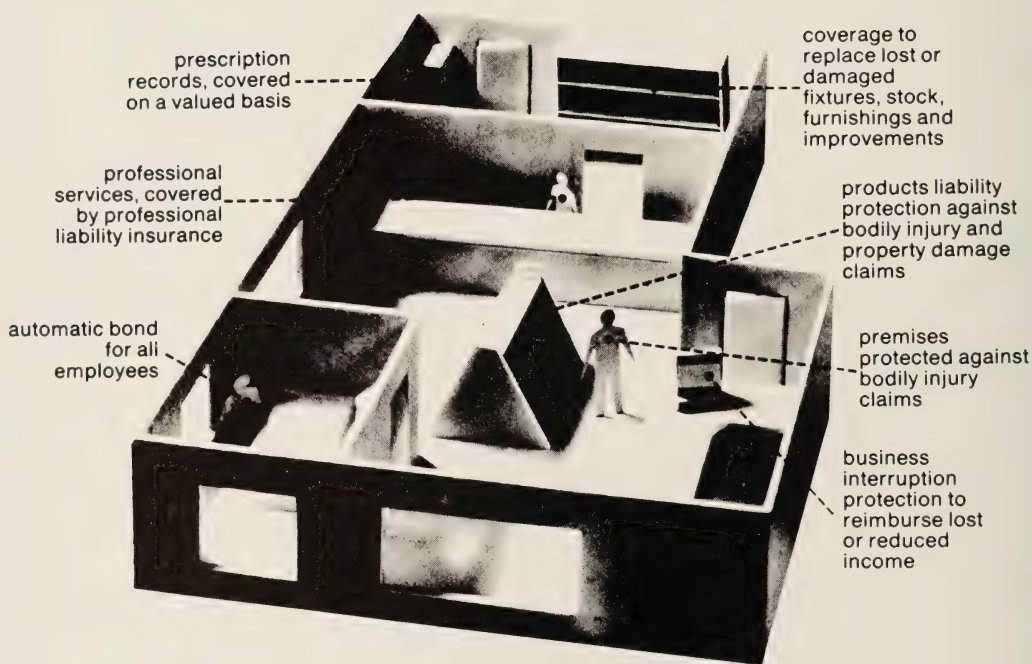
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The 1981-82 Third Party Chart

**Frontiers of Pharmacy Practice
in a Family Practice Setting**

— Robert E. Davis

Lilly Digest

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I finish my year as President of the Maryland Pharmaceutical Association with many unsolved problems and unanswered questions. It certainly would have been unrealistic to expect to finish otherwise. Much has been accomplished by the member of the organization which is more broadly representing Pharmacy and Pharmacists in the state and the nation.

Our last convention of the first century of the Association's existence will be of vital importance to each and every Pharmacist in the State. Thanks to Dave Banta we will be conducting joint sessions with our neighbors from Delaware. Maybe our centennial year will realize our efforts in having such a venture with our colleagues in the Maryland Society of Hospital Pharmacy.

Our efforts this year have been geared toward positive action in establishing goals and objectives for the profession. Many of the workers in our Association have been working for years. This year an increase in the number of new members and workers is allowing us to progress.

Fiscal constraints seem to plague all Pharmacists in all practice environments. Working together we can provide the health care industry and the recipients of that health care with a broader scope of service in all of our endeavors. The Coordinating Council on Continuing Education has completed a year of outstanding activity. Madeline Feinberg has provided Pharmacists with an opportunity to reach large groups of senior citizens with the Elder Ed Program.

Many thanks are due to the active committees of the Association for their efforts this year. My efforts for the Association this year have been severely limited due to my change of practice environment. Thanks to Dave Banta, Mel Rubin, Dean Bill Kinnard, Ron Kibman, and the Association's office staff, our efforts in behalf of you the members are ever expanding. Remember that our actions today will be recognized for their worth tomorrow. Remember, we all get what we deserve — like it, or not.

In the words of Donald C. Brodie, Ph.D., recipient of this year's Harvey A. K. Whitney Award, "The uncertainties of the new decade can only be successfully negotiated by pharmacists if they establish a new professional ideology that confidently envisions a society enriched by the practices and services of Pharmacy. We either accept for Pharmacy, what the future brings or work to shape the future in accordance with what we want the future to be."

The unanswered questions of P.D., Pharm.D., supportive personnel recognition, mandatory C.E. & Patient Profiles — what part will all of the answers play in molding the future role of Pharmacy? How will we plan to provide ambulatory and home health care?

The real world awaits us and our efforts to serve them.

Thank you to all for your efforts. Please continue. See you in Ocean City.

Samuel Lichter

Frontiers of Pharmacy Practice in a Family Practice Setting

by
Robert E. Davis, Pharm.D., R.Ph.

(Dr. Davis participated in the March 19th C.E. program on "Primary Care"
sponsored by the Continuing Education Coordinating Council.)

Introduction

In recent years the practice of medicine has seen the development of a new concept, that of a team approach to the care of the entire family. Medicine and pharmacy are becoming too complex for the individual professions to perform efficiently and effectively alone. The general practitioner has now specialized in family practice, the nurse is able to obtain additional training as a family nurse specialist and the pharmacist is able to obtain advanced academic and clinical training specializing in family practice. This team provides a cooperative approach to the delivery of health care. The concept and role model are discussed in this paper.

Lexington Family Practice is located in a rural-suburban area on the perimeter of Lexington, South Carolina, approximately fifteen miles from the capitol city of Columbia. The area is considered rural in that in 1975 the town's population was 976 and its primary income was agricultural. However, it is now becoming an industrial area and a bedroom community for government employees causing the population to increase rapidly. Approximately five thousand people move into the county each year; therefore, the patient load is now moving more toward that of a suburban practice.

When the center opened in the summer of 1976, it was unique in that it was a totally privately financed ambulatory health care center practicing a team approach to health care. It was also unique in that a fee was paid by the patient to the pharmacist for consultation services. The concept has been successful in South Carolina with eight facilities similar to Lexington Family Practice now operating.

ROBERT E. DAVIS, Pharm. D., R.Ph., Lexington, South Carolina is the clinical pharmacist in the Lexington Family Practice—a practicing relationship between a clinical pharmacist and three physicians. This innovative family practice sees over 1500 patients monthly and fills 3000 prescriptions each month. Dr. Davis received both his B.S. in Pharmacy (1974) and his Doctor of Pharmacy (1975) degrees from the College of Pharmacy, Medical University of South Carolina. He was the recipient of the Arnold and Marie Schwartz Award, the National Award of the American Pharmaceutical Association, in 1978 for his contribution to pharmacy practice. Dr. Davis has published many articles about this new concept of family practice and is much sought after as a lecturer on that topic.

Concept and Model Plan

The concept originated during the training of the partners, Bill Crigler, Bob Davis and Hank Martin, at the Department of Family Practice of the Medical University of South Carolina. Physicians had daily contact with and exposure to the services offered by the pharmacy. The physicians became aware of the time the pharmacist could save them by counseling the patient on medications, of improved compliance and of the safeguard of having the pharmacist screen for drug reactions and interactions.

The acceptance of the concept by the community is seen by the growth of the practice. In 1979 a third family practitioner was added and the building enlarged from 4300 to 7000 square feet. Currently the yearly gross of the three physicians and pharmacist is over \$750,000. LFP employs three family physicians, four nurses, a clinical pharmacist, two prescription oriented pharmacists, a pharmacy technician, a lab technician, a lab assistant and a business office staff of six.

The pharmacy uses approximately 20% of the building. It has four basic components; the consultation rooms, the dispensing area, the clinical pharmacist's office with library, and the waiting room. The consultation room is used to greet the patient and provide clinical services. The dispensing area resembles any professional pharmacy where medications are stored and prepared for dispensing. The waiting room provides a professional area for the patients to read educational materials and relax while waiting for prescriptions to be filled. The fourth component, the clinical pharmacist's office including the library, is used for research and business operations. The medical area uses the remainder of the building which consists of business offices, waiting room, examination rooms, nurses's station, lab, minor surgery and library.

Pharmacy Services

In the practice the clinical pharmacist is responsible to the patient, physician, and students. The pharmacist provides consultation with the patient which includes a drug history and beginning the profile card which includes current medication, allergies and idiosyncrasies; a review of the prescription looking for drug duplication, interactions, allergies; calculating dose; discussing directions, compliance and clinical side effects; providing educational material and answering patient questions. Consultation with the physician is provided for choice of drug in therapy, dose calculations, fol-

low-ups in chronic patients, new drug information, literature reviews for educational purposes and possible adverse reactions. For the student the clinical pharmacist provides a role model and an environment to gain practical experience.

The clinical pharmacist also provides blood pressure checks to monitor chronic patients. During the encounter he monitors compliance, side effects and adverse reactions and provides educational materials.

Medical sales representatives meet with the clinical pharmacist to provide detail information for the physician and educational material to the pharmacist. The information from the sales representative is reviewed by the pharmacist and presented to the physician.

To decrease physician phone time the clinical pharmacist will triage incoming calls to decide whether patients need visits or O-T-C treatment. All O-T-C products are mutually chosen by physician and pharmacist.

Hospital rounds are made to provide continuity of care for patient from outpatient to inpatient and discharge. Charts are reviewed for drug related problems and drug information can be provided to the physician. On discharge all prescriptions are reviewed for patient understanding.

Model Flow

The routine procedure for a patient visit can be outlined as follows. The patient checks in with the receptionist and is given forms to fill out concerning past medical, pharmacy, and family history. After these are completed, the receptionist notifies the nurse, who ushers the patient to the examination room, records the vital signs and obtains the chief complaint. The physician then reviews and evaluates the patient and after a diagnosis is made initiates a plan of therapy with or without pharmacy consultation. He then writes a prescription and dictates into the problem oriented medical record. The nurse gives the patient further instructions about the disease or process and takes specimens for any lab work that is necessary.

At this point, the patient is referred to the pharmacy consultation room. The clinical pharmacist is given the patient's record and prescription. The information in the chart is vital to this concept of practice and enables the pharmacist to discuss the use and indications of the medications with the patient. The prescription is next reviewed with the patient and questions are answered.

The patient then has the choice of having the prescriptions filled at any pharmacy. If the patient chooses the center pharmacy the technician and pharmacist prepare and dispense the medications. Finally the patient returns to the receptionist where the entire visit, including physician visit, lab fees, and pharmacy charges are paid by one method of payment.

Fee System

The clinical pharmacist is paid a fee for all of the above mentioned consultation services. This fee is derived directly from patient receipts and is charged to every patient whether or not any prescriptions are filled in the pharmacy. It was initiated because the availability of a clinical pharmacist's time is not only important but valuable and enables the clinical pharmacist's salary to be based on his availability to the patient and the physician and not on how many prescriptions are filled.

Dispensing of Medications

It is believed that dispensing a patient's medication from the center is to the patient's advantage and this was therefore initiated at our center. Some of the advantages that we felt to be important are as follows:

1. Convenience to the patient. It offers a convenient system which allows the patients of ill children, people with busy schedules or the elderly to have their medications filled immediately after receiving the physician's services.

2. Savings to the patient. The physicians follow a formulary which allows the pharmacy to purchase on contract various pharmaceuticals in large volumes, thus obtaining discounts which are passed along to the patient. Also, all medications are dispensed at the cost of medication plus a professional fee.

3. Improvement in compliance. The patient has a very good understanding of why he or she is taking the medication and what is expected of him or her from the physician and the pharmacist; the patient is more apt to follow directions fully, thereby improving compliance. To improve patient compliance in chronic illness, refills are monitored and the need to take the medication regularly is verbally reinforced during the patient's monthly visit to the pharmacist.

4. Assurance of a quality product. Each product selected for our formulary is reviewed by the pharmacist for problems in bioavailability and for acceptance by the patient. The cost, dosage form and schedule are considered in the assessment of patient acceptance.

Summary

This paper has described the concept, the establishment, the practice model procedure, the patient flow, the pharmacist's roles and the fee charged for a pharmaceutical component within a family practice center. This setting allows the physician, the nurse and the pharmacist to interact in the treatment program of the patient. It allows the pharmacist and nurse to become integral parts of the health care team. The physician, amidst the complexities of therapeutics, has a close working ally in the pharmacist. The uniqueness of the system allows the pharmacist to concentrate on drug education and consultation, and rewards him for time spent which is not directly related to the dispensing activity. The program has been well received by the community, both the professional and private sector; this is evident from the growth of this practice and others like it since the opening of Lexington Family Practice in August 1976. In the future, the center will be expanding its services to include more physicians, nurses and additional ancillary personnel.



Guidelines Available

A set of guidelines on clinical pharmacy service reimbursement, has been developed by the ASHP Task Force on Payment for Pharmacy Services and approved by the ASHP Board of Directors.

According to the Task Force report, there are generally no policies of Blue Cross plans, private insurance companies or other third-party carriers prohibiting reimbursement for clinical services. However, the Task Force reported, "support is predicated upon acceptance and endorsement of the service by the involved administrative and medical staffs."

The ASHP *Guidelines for Implementing and Obtaining Reimbursement for Clinical Pharmacy Services* state that, until these services become the "norm" of practice, certain administrative requirements must be met to implement new clinical services. These are: (1) approval from the institution's administration for provision of the service on a routine basis; (2) the delineation of costs of the service and an appropriate patient charging mechanism; and (3) reimbursement and payment for the provider.

The ASHP-approved guidelines provide a general description of how to obtain administrative support and reimbursement for a new pharmaceutical service. Seven steps — from the preparation of a written proposal for a trial implementation project to reports on service impact — are outlined.

The guidelines document specifies that this outline for reimbursement pertains to payment to institutions or other organized providers for the costs of pharmaceutical services; the guidelines may be adaptable to direct reimbursement as well.

A free copy of the guidelines can be obtained by sending a self-addressed, stamped envelope to ASHP, Membership and Publication Records, 4630 Montgomery Ave., Washington, D.C. 20014. (Quantity prices are available.)

Reunion Held

This year marked the 25th anniversary of the graduation of the class of 1956.

It was June 9, 1956 when forty-five members of the School of Pharmacy walked down the aisle of Cole Field House at College Park and received their diplomas from Dr. Noel Foss, then dean of the school.

On April 4, 1981, thirty of the forty-five in the class met for a reunion at the Pikesville Hilton. Also present was Dr. Casimir Ichniowski. Dr. Ich, as he is known, just recently retired as assistant dean of the school. In 1956 he was the Professor of Pharmacology and the class advisor.

The reunion actually began earlier in the day, just before noon, with a tour of the School of Pharmacy. There was amazement at the improvements in the facilities and the increase in the number of faculty. In the intervening years the pharmacy program grew from four to five years. Many of the course offerings are the same now as then. Others such as biopharmaceutics and pharmacodynamics were not even words in the vocabulary. In 1956 no thought was given to computers for pharmacy practice. Today, the model pharmacy utilizes two different types to demonstrate their usefulness. — MARVIN OED

The Maryland Graduate Chapter of Kappa Psi Pharmaceutical Fraternity is being revitalized in Baltimore

For further information call

Jim Apostolou665-1100 Gino Marzella561-0975
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LETTERS

Dear Mr. Banta:

The American Society of Hospital Pharmacists has just published the *Pocket Guide to Injectable Drugs* by Lawrence A. Trissel. This new publication is an easy-to-use, convenient reference source for reliable information on the most frequently used injectable drugs. The *Pocket Guide* is an abbreviated version of the parent publication, ASHP's acclaimed *Handbook on Injectable Drugs*.

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- a convenient tabular description of compatibility with base solutions and drugs
- complete cross-indexing of generic and proprietary names.

The price of the 159 page *Pocket Guide* is \$10.00. Copies may be obtained by writing to:

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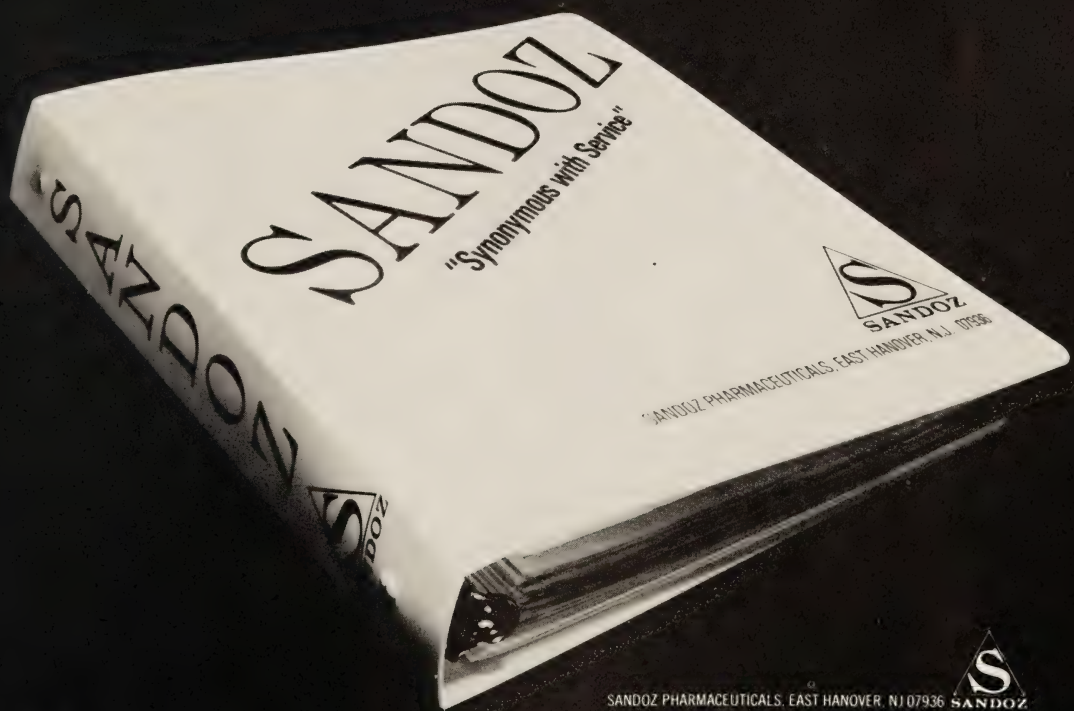
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The 1981

Lilly Digest

This year's preliminary *Lilly Digest* report, based on 1980 operating statistics from 851 independent community pharmacies, indicates lower cost-of-goods and expense figures that resulted in higher gross margin and net profit before taxes. When the income and expense statement items are expressed as percentages of total sales and compared with *Lilly Digest* figures for 1979, they show that . . .

Total sales attained a new high of \$419,021, a \$27,340 increase (7.0 percent) over 1979 sales. This rate of increase is somewhat lower than the average annual growth rate of 7.7 percent observed over the past decade. Prescription sales showed a 9.6 percent gain over the previous year's figure and significantly outpaced other sales, which advanced 4.4 percent. Total prescription sales accounted for just over half of the independent community pharmacy volume at 51.0 percent (up from 49.8 percent in 1979).

The cost of goods sold declined 0.1 percent to 65.6 percent of sales, which caused gross margin to rise to 34.4 percent from 34.3 percent recorded in 1979. Total expenses also decreased as a percent of sales to a new low of 30.9 percent (down from 31.3 percent in 1979). This percentage reduction was the collective result of manager's salary, employees' wages, and rent more than offsetting the increase in miscellaneous operating costs. The combined effect of these changes was the significant increase in net profit before taxes to 3.5 percent (up from 3.0 percent in 1979), just above the 1977 level of 3.4 percent.

Although total expenses declined as a percent of sales, they did rise in terms of dollars (up \$6,544, or 5.3 percent, from the 1979 figure). The average proprietor's salary also was higher in dollars (up \$682) but fell as a percent of sales from 6.5 to 6.2 percent. Similarly, em-

ployees' wages increased in dollars but were lower percentagewise when compared with averages for 1979 (down 0.2 percent to 11.7 from 11.9 percent). As a percent of sales, rent fell slightly from 2.5 to 2.4 percent. However, average rental expense rose \$396 to post a 4.0 percent gain over the 1979 figure. Dollarwise, net profit before taxes showed a 27.2 percent increase over the previous year (up \$3,162). This was the largest annual net profit gain in recorded history for *Lilly Digest* participants. Total income (proprietor's salary plus net profit, before taxes) improved both in dollars and as a percent of sales (\$3,844 and 0.2 percent respectively).

Prescription inventory and merchandise inventory required more dollars; however, both dropped percentage-wise (from 11.8 to 11.5 and from 20.9 to 20.5 percent of sales respectively). The

prescription department's sales productivity moved up to \$8.67 per stock dollar (1.8 percent higher), while other merchandise productivity rose to \$4.87 from \$4.78 (up 1.9 percent).

The share of new prescriptions remained at 49.7 percent of total prescriptions dispensed (up 0.9 percent from the previous year's level). Renewed prescriptions were higher by 109 than the 1979 figure but were unchanged as a percent of total prescriptions dispensed. As a result, total prescriptions continued a two-year growth trend, showing an increase of 228 prescriptions dispensed. During 1980, 27,415 prescriptions were dispensed in the average independent community pharmacy (0.8 percent more than in 1979). The average prescription charge rose to \$7.80 during 1980, up 62 cents (8.6 percent) over the 1979 figure of \$7.18.

The following table summarizes the preliminary *Lilly Digest* report of the 1980 operating figures for 851 independent community pharmacies and compares these with the 1979 *Lilly Digest* averages from 1,458 pharmacies. The annual *Lilly Digest* will be completed and distributed in September, 1981.

LILLY DIGEST PRELIMINARY REPORT — 1981

Averages per Pharmacy	1980 (851 Pharmacies)		1979 (1,458 Pharmacies)		Amount and Percent of Change	
Sales						
Prescription	\$ 213,812	51.0%	\$ 195,159	49.8%	+\$ 18,653	9.6%
Other	205,209	49.0%	196,522	50.2%	+\$ 8,687	4.4%
Total	\$ 419,021	100.0%	\$ 391,681	100.0%	+\$ 27,340	7.0%
Cost of goods sold	274,968	65.6%	257,334	65.7%	+\$ 17,634	6.9%
Gross margin	\$ 144,053	34.4%	\$ 134,347	34.3%	+\$ 9,706	7.2%
Expenses						
Proprietor's or manager's salary	\$ 26,028	6.2%	\$ 25,346	6.5%	+\$ 682	2.7%
Employees' wages	49,054	11.7%	46,759	11.9%	+\$ 2,295	4.9%
Rent	10,179	2.4%	9,783	2.5%	+\$ 396	4.0%
Miscellaneous operating costs	44,015	10.6%	40,844	10.4%	+\$ 3,171	7.8%
Total expenses	\$ 129,276	30.9%	\$ 122,732	31.3%	+\$ 6,544	5.3%
Net profit (before taxes)	\$ 14,777	3.5%	\$ 11,615	3.0%	+\$ 3,162	27.2%
Total income (net profit plus proprietor's salary, before taxes)	\$ 40,805	9.7%	\$ 36,961	9.5%	+\$ 3,844	10.4%
Value of inventory at cost and as a percent of sales						
Prescription	\$ 24,666	11.5%	\$ 22,941	11.8%	+\$ 1,725	7.5%
Other	42,095	20.5%	41,125	20.9%	+\$ 970	2.4%
Total	\$ 66,761	15.9%	\$ 64,066	16.4%	+\$ 2,695	4.2%
Annual rate of turnover of inventory	4.3 times		4.2 times			
Number of prescriptions dispensed						
New	13,618	49.7%	13,499	49.7%	+	0.9%
Renewed	13,797	50.3%	13,688	50.3%	+	0.8%
Total	27,415	100.0%	27,187	100.0%	+	0.8%
Average prescription charge	\$ 7.80		\$ 7.18		+\$ 0.62	8.6%

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“P.D. or not P.D.”

What is the Question??

Editorial Comment by
Nancy A. Baros

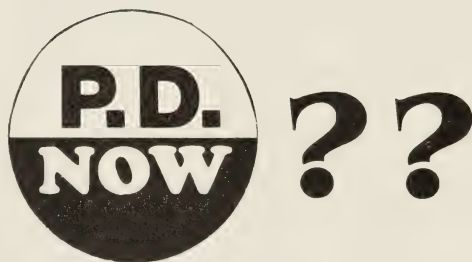
As evidenced by the recent P.D. Debate, sentiments are running high over the P.D. issue. But the issue is not as simple as yes/no should we adopt the P.D. designation. The P.D. question is balanced precariously on a foundation of underlying issues which need consideration before any designation should be adopted.

If the profession arbitrarily adopts a P.D. designation, what are the benefits? Potentially, it could give some aspect of unity to the profession. It might serve to upgrade the profession. The potential adverse effects are just as nebulous. Some fear that arbitrarily adopting the P.D. will bring disapproval from outside the profession — a self-anointing that means nothing. It has already demonstrated its ability to further fractionate the profession.

The question does not appear to be if we should try to upgrade the professional image. Nor does the issue appear to be one of the inappropriateness of the R.Ph. designation or of unifying the profession. Most pharmacists agree on these issues. The question is; will an arbitrary assignment of the P.D. designation do any of these things? P.D. can work — but not as a gift we give ourselves. What we need to investigate are ways to restructure curricula or continuing education to justify the P.D. designation.

Depending on the perspective with which you approach the issue, you will find differing opinions on the underlying cause. From my perspective, the P.D. issue centers on the inequity of the current pharmacy B.S. degree. Where else can you get one for the price of two? Pharmacists feel cheated receiving a four year degree for five years of blood, sweat and tears. If their own profession denigrates them in this manner, how do they expect other professionals and the public to confer esteem on them? And how much esteem will be gained by arbitrarily tagging the initials P.D. after every pharmacist's name.

Before we go charging headlong into the forest after the beast, let's make sure it's the right beast. We can't resolve one inequity by creating another. To assign a P.D. designation without backing it with something substantial gains no-



thing. If we want P.D. to bring esteem, then we have to show that it's worth something.

I think our first efforts should be directed at identifying the right beast. If the problem stems, as I believe, from the five year B.S. degree — then give the program its rightful M.S. degree. If the profession feels that some uniform doctorate degree is the future of pharmacy, then structure programs to confer a P.D. degree. Adjust the current curriculum to a six year program conferring a P.D.. Change the 19 and 22 credit semesters to more feasible 16 or 17 credit semesters. Make a course in OTC products part of the curriculum and *open to all students*. Institute a course in current pharmacy issues. Make a few more electives available and you will have a six year program. At the same time offer evening course for pharmacists who wish to return to school and earn a P.D. degree.

Another option for pharmacists already graduated would be to base a P.D. designation on three years experience *and* a requirement of 15 hours of continuing education annually. Then those pharmacists desiring a P.D. designation could easily attain it and it would actually represent something. Those pharmacists not wishing a P.D. designation need not apply for the designation. To those outside the profession, I am sure there are those that will argue with this proposal. But if we are going to try to upgrade the profession — let's make it a sincere effort, not the sham that an unrestricted P.D. designation would be.

Nancy is a graduating Pharmacy student and wrote this article during her P.E.P. rotation in the Association office.

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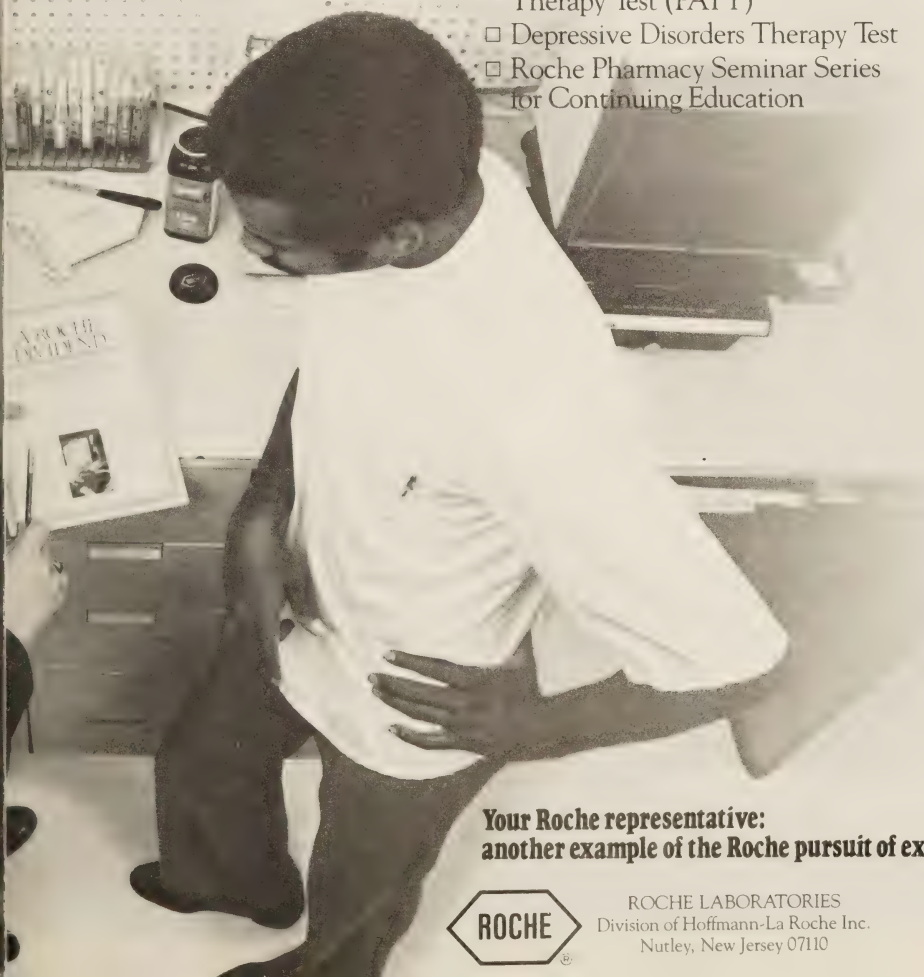


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FDA is 75

The Food and Drug Administration begins commemoration of the 75th anniversary of the Pure Food and Drugs Act, the first federal law to provide protection to consumers from dangerous, adulterated and misbranded food and drug products.

The anniversary year will be marked throughout the United States by scientific symposiums on current and continuing problems, by programs at meetings of professional organizations, and by educational exhibits, including one at the Smithsonian Institution.

Poisonous preservatives and dyes in foods, and cure-all claims for worthless and dangerous patent medicines, led to the enactment of the law, which was signed by President Theodore Roosevelt on June 30, 1906. On the same day, he signed the Meat Inspection Act, a product of disclosures of insanitary conditions in meat packing plants. Both laws were initially enforced by the Department of Agriculture.

Today, the successor to the Pure Food and Drugs Act of 1906 — the Food, Drug and Cosmetic Act of 1938 — is enforced by the Food and Drug Administration, one of six agencies in the Department of Health and Human Services' Public Health Service. The Meat Inspection Act is enforced by the Department of Agriculture.

In a memo sent to all FDA employees, Commissioner Jere E. Goyan said:

"We begin a year of special significance to consumers, industry, the scientific community, and ourselves. We will be observing in various ways the 75th anniversary of this great law which constitutes our mission as servants of the American people . . .

"Our purpose is four-fold:

— "A searching study of our own past and present, looking toward a future of greater services as a scientific, law enforcement institution.

— "Better understanding of today's baffling problems of consumer protection, as contrasted with those of the past.

— "Appreciation of the role and contributions of consumers, science, and industry to effective operation of the food and drug laws.

— "Better public understanding and support of our food and drug laws, Federal, state, and local."

FDA will apply the 75th anniversary theme to activities that would take place anyway such as scientific symposiums sponsored by FDA's Office of Health Affairs and Bureaus. The agency also will co-sponsor an anniversary symposium conducted by the Food and Drug Law Institute June 8 in Washington. FDLI is an independent organization of lawyers in the food and drug field.

During the anniversary year, FDA also will participate in meetings sponsored by the American Pharmaceutical Association, the American Institute of History of Pharmacy, the Association of Food and Drug Officials, the National Food Processors Association, the Animal Health Institute, the American Dental Association, the American Medical Association and the American Academy of Pediatrics.

A videotape prepared for internal training employs the anniversary theme, and in June 1981, there will be a special issue of *FDA Consumer*, the agency's official magazine.

Educational exhibits will also be set up in the lobby of the Hubert H. Humphrey Building, the main building of the Department of Health and Human Services in Washington, and in the 32 cities where FDA has regional or district offices.

Abbreviated Calendar of Planned Anniversary Events in 1981:
Smithsonian Institution exhibit, May and June, Washington, D.C.

Exhibit in the 32 cities where FDA has regional or district offices in place by June.

Food and Drug Law Institute Symposium and Banquet, June 8, Washington, D.C.

US Department of Agriculture's marking of anniversary of the Meat Inspection Act, June. Plans being completed.

Science in Medicine symposium at Emory University, Oct. 15 and 16.

The anniversary will also be marked by exhibits, programs or awards at meetings of the:

International Exposition for National Food Processors, Feb. 15, San Francisco.

American Academy of Pediatrics, April 4-9, Washington, D.C.

American College of Physicians, April 6, Kansas City.

Association of Food and Drug Officials, June 14-17, St. Louis.

American Society of Animal Science, July 26-29, North Carolina State.

Highlights of Events Scheduled to Commemorate The 75th Anniversary of the Pure Food and Drugs Act of 1906

FDA Consumer Commemorative Issue.....June 1981

● INSIDE FDA

BUREAU OF VETERINARY MEDICINE

Mycotoxin Animal ConferenceJune 1981

Animal Health Institute and BVM Conference...June 15-16, 1981
Washington, D.C.

American Society of Animal ScienceJuly 26-29, 1981
North Carolina State

BUREAU OF FOODS

Nutrition Seminar.....August 1981

Risk Assessment WorkshopSeptember 28, 1981

Health Effects of LeadTentatively May 1981

● OUTSIDE FDA

American Academy of PediatricsApril 4-9, 1981
Washington, D.C.

American College of PhysiciansApril 6, 1981
Kansas City

American Society of Hospital PharmacistsJune 1981

USDA Commemorating the Signing of the Meat Inspection
Act of 1906June 1981

Food and Drug Law Institute SymposiumJune 8, 1981

American Pharmaceutical Association
(Breakfast with FDA Pharmacists).....June 8, 1981
Washington Hilton

Association of Food and Drug Officials
Diamond CelebrationJune 14-17, 1981
St. Louis

Association of Official Analytical
Chemists SymposiumFall 1981

American Dietetic AssociationSeptember 22-24, 1981

American Public Health AssociationOctober 1981
Los Angeles

American Dental Association (FDA Speakers)October 1981

Emory University "Science in Medicine"October 15-16, 1981

American Osteopathic AssociationNovember 1981
Los Angeles

He knows the practice of pharmacy inside and out.

In fact, during the years since he graduated from pharmacy school in 1964, he has done everything but teach it.

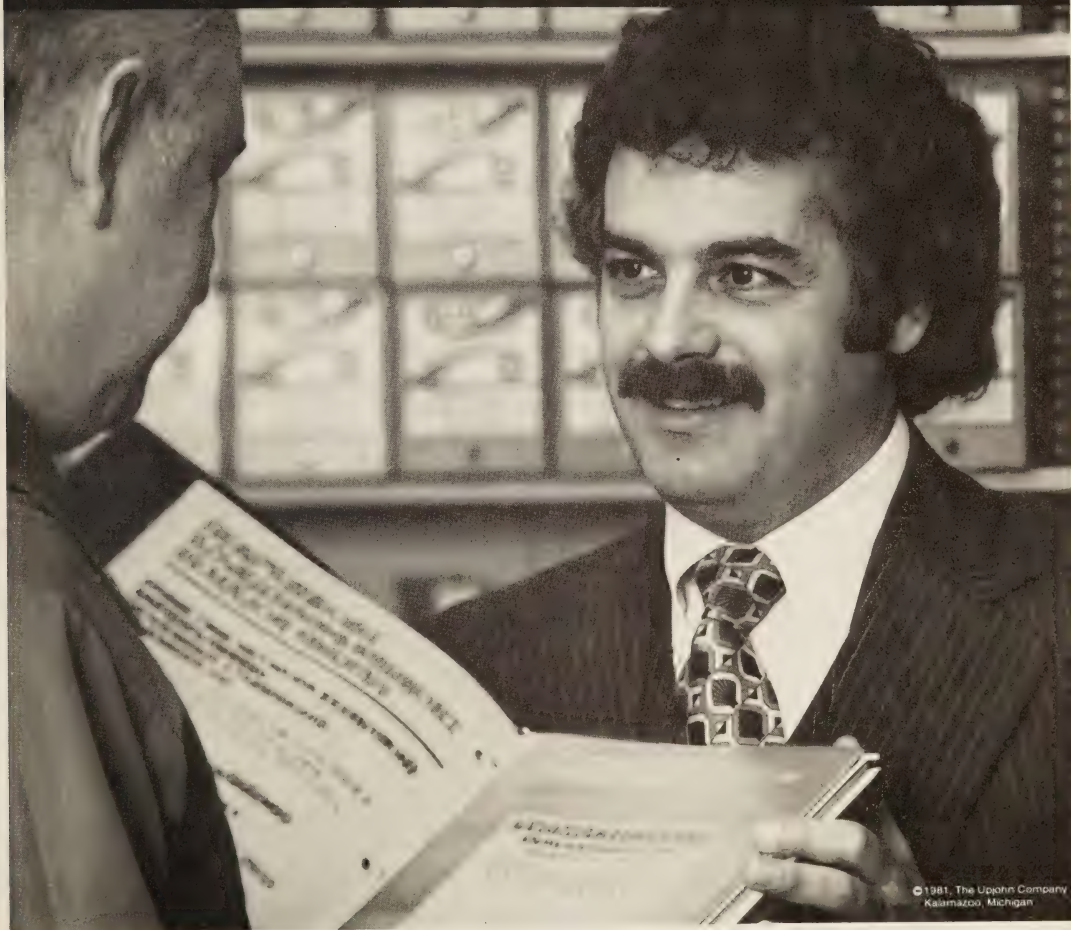
Before joining Upjohn in 1973 as a sales representative, Vince worked as a pharmacist in a community drug store; in a small chain drug store; in a large chain drug store; and as assistant director of pharmacy at a large hospital.

This experience has given Vince a strong personal insight into the needs of other pharmacists. His background, training and continuing education all help Vince provide information and service to pharmacists in his area.

Vince is one of several hundred pharmacists at Upjohn who are proud of their role as members of the health care team—and their partnership with your side of the counter.

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The 1981-82 Third Party Chart

(detach these
pages and post
for easy reference)

Special Thanks to

Leslie Goldstein

Mike Ball

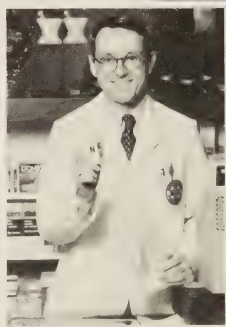
Nancy Baros

for compiling this chart

This chart is available to non-members for
only \$5.00. Contact MPhA office for details.

	Cost	Professional Fee	Maryland Rx Only/ Local Ordinance	OTC	BC	Insulin on Rx	Refills	Day & Dollar Limit	Claim Form	Misc.
Aetna Life and Casualty Group Policyholder Administration Pharmacy Claim Unit 151 Farmington Avenue Hartford, Connecticut 06156 (800) 473-4728	ACQ	\$3.10	No/No	No	Most don't	Yes	1 year	34 days with exception list	Universal	Must send with transmittal form
Associated Prescription Service (APS) The Chesapeake Building 9017 Red Branch Road Columbia, Maryland 21045 (Baltimore) 955-1941 (Wash.) 621-5150	AWP	By individual fund \$2.75-2.81, 26.30-34, 36-41, 45.47, 50.66-7, 71.87, 103.112-3, 115-6, 119, 120, 123-5, 127, 129, 139, 140 \$2.70-85.285 \$2.50-109, 110, 122, 130-2, 145 \$2.25-9.14, 17.21-2.24-5, 26-31-2, 39.42-4.46-48, 49.55-59.75, 77.8-80-4, 89.93-96, 100, 105, 107, 110-114, 116, 121-126, 147-8, 151-164 \$2.00; all others compounded with 3 or more ingredients; \$1.25 prof. fee	Yes/Yes	some do—refer to specific plan	some do— see plan	most cover insulin some cover syringes	1 year	see plan for day exception list \$30 max	Universal	no injectables given where feasible
Blue Cross of Maryland 700 East Joppa Road Towson, Maryland 21204 828-4360	ACQ	\$3.10	Yes/No	No	No	yes syringes— see book	1 year	greater of 34 days or 100 doses no dollar limit	Universal	maintenance drug list; 100-200 day limit

Medicaid Medical Assistance Operation Admin State Dept of Health and Mental Hygiene P.O. Box 383 Baltimore, Maryland 21203 383-2658	ACQ or MAC	lower of U + C or \$2.25	Yes/Yes	some family plan- ing products, insulin syringes schedule V cough preparations	yes 180 day limit	Yes, if on Rx	Two days, if on original Rx	100 day max, in- cluding specified refills. Pre- authorized if over \$40.00	Medical Assistance	Red & White card- \$0.50 deductible Yellow/White card- \$1.00 deductible MAC program
Metropolitan Medimet Claim Office P.O. Box 56 Utica, New York 13503 (315) 797-5405	ACQ or AWP varies	\$2.50	Yes/Yes	some, check list	some, check list	Yes	1 year	100 days except for GM Hecht VW which have speci- fied maintenance lists — 34 days or 100-200 units	Universal	
1199 National Benefit Fund Prescription Plan 310 West 43rd Street New York, New York 10036	AWP	\$2.60 \$1.00 extra for com- pounding	Yes/Yes	No	30kg max no diaphragm	Yes Cost + 50% no syringes	Five within 6 months	10 days supply 34 day maintenance greater than \$50 requires phone authorization	Their own	If prescribed by generic, will only pay generic Rx older than 6 mo. not payable
Paid Prescriptions P.O. Box 434 Paramus, New Jersey 07652 (201) 845-9000 1-800-631-1679	Plans 2A,3 3B — ACQ ACQ Others, AWP	Group 1/Group 2 Acme Mkts. \$1.85 \$2.10 UPS \$2.95 \$3.20 Allegheny Agronomy, PBS Provident Bakery & Confection, Hoerschchild A & P Boeing Travelers Presbyterian Pet Clerks Michellin \$2.25 \$2.50 \$2.00 \$2.25 \$2.25 \$2.25 \$2.25 \$2.25 \$2.60 \$2.60 \$2.60 \$2.60 \$2.00 \$2.25 \$2.00 \$2.25 \$2.95 \$3.20	Yes/No	3B	4.4A, 6.6D- up to 3 mo. no diaphragm	Yes Cost + 50%	Per MD and state law	Plans 4.5, 6.6D, 7 34 days or 100 units Plans 3, 3B, 5A 100 days-refers to maintain list 200 units Plans 2A, 2S 34 days Plan 4A — 100 units Plan 5B — 60 days	Paid Form state age Universal date of birth	Plans 25, 6, 6D, 7 include syringes
Pharmaceutical Card System (PCS) P.O. Box 20831 Phoenix, Arizona 85036 (602) 257-1500	Plans 20,83 115,315 Others AWP	\$3.19, 269, 376, 304 \$3.00, 191, 203, 308 \$2.95, 100, 134, 165, 195, 252 — 191, 207, 216, 272, ACQ 300, 310, 315, 327, 329, 429 \$2.85, 387, 412, 438 \$2.80, 200, 213, 256 \$2.65, 020, 152, 232, 252, 172, 420, 430 \$2.62, 112, 195 \$2.50, 222, 386 \$2.15, 097 \$2.10, 361	Plans 104, 105, 115, 121, 152, 195, 252 — Yes/No All others — No/No	Plan 166 allows Urinary sugar tests	Plan 195	Yes Cost + 50%	1 year	31 — no limit 104, 105 — greater of 34 days or 100 doses 115 — 100 days 195 — 34 days 329 — 34 days 40 doses of 400 402 cream or oint see exception list	Universal	Include drug name on form
Pharmaceutical Service Foundation P.O. Box 10472 Baltimore, Maryland 21209 466-1183	AWP	Members — with patient profiles, \$3.10 others: \$2.75 Non-members: \$2.50	Yes/Yes	No	No	Insulin only	Max of 5	34 days except maintenance drugs & antibiotic up to 100 doses	Universal	Include drug name and NDC on form No flu vaccine or immunizations Computer printout acceptable
Prescription Drugs Inc. (PDI) 9008 Red Branch Road Oakland Ridge Industrial Park Columbia, Maryland 21045 997-3350	ACQ	\$2.50	Yes/Yes	one fund only	indicated on card	yes	Max of 5	greater of 34 days or 100 doses	Universal	
Prescription Plan Service (PPS) 500 Eighth Avenue New York, New York 10018 (212) 279-5950		Refused to provide information								
Travelers Insurance Company LAGRAM Claim Department P.O. Box 5307 Hamden, Connecticut 06518 (203) 277-7108	Plan 1 ACQ Plan 2 AWP	\$2.80	No/No	No	No	Yes	1 year	34 day specified mainte- nance list — 100 doses	Universal	Must be member pharmacy Covers needles & syringes



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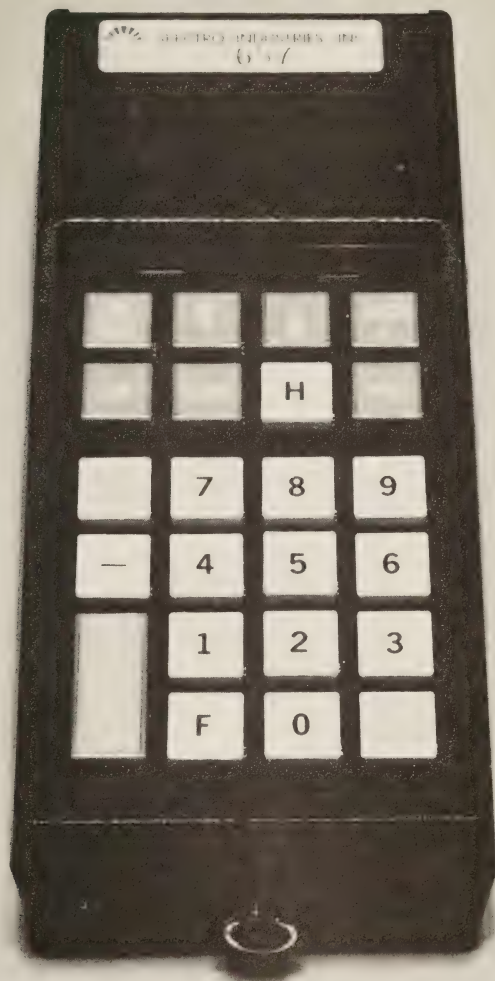


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AMA DRUG
EVALUATIONS
C I B A



Alumni Association President Sanford Rosenbloom (left) presents the Honorary President's Award to Dean E. Leavitt (right), Associate Dean at the University of Maryland School of Pharmacy. The Annual Dinner Meeting of the Association was held on March 8, 1981.



John S. Toll, President of the University of Maryland presented remarks to the Alumni and friends.



John Money, Professor of Medical Psychology at Johns Hopkins University presented an address on "Homosexual Sheep on the Pharmacist's Farm, what they tell you about your children."




T. Albert Farmer, the new Chancellor of the University of Maryland at Baltimore Campus brought greetings to the Annual Dinner meeting which was held at the Forum in Baltimore.

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"I have to find the best answers for everything from purchasing to pricing—from personnel policies to security practices—for my four pharmacies. The success of my business depends on making the right decisions."

We hear you, Wesley Shelton

As part of SK&F's pharmacy services, there are several programs available that can help pharmacists with day-to-day managerial problems like those mentioned by Mr. Shelton.

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- **A Quarterly Publication for Pharmacists, edited by Mickey Smith, Ph.D., University of Mississippi.** A journal featuring concise, objective analyses of current issues bearing on the pharmacy profession.

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How to Learn Medical Terms by Knowing Prefixes and Suffixes

by
Stephen J. Provenza, Pharm.D.

In order to practice Clinical Pharmacy effectively, the pharmacist must be able to understand the terminology that is used when clinical cases are discussed. In this connection, the words used by physicians represent "another language."

We can trace our medical terminology to the Greek language which is rich in medical history. It emerged as a mixture of mythology and rationality. From Greece, this knowledge went to Rome where it prevailed until about the year 500 A.D.

Greek and Latin

With the fall of the Roman Empire, there was an east-west territorial division, and Byzantium became capital of the eastern half. From the latter, the great manuscripts were translated into Arabic from which — later in the 11th century — they were translated into Latin.

Thus, our medical terminology is almost exclusively Greek and Latin. Therefore, we have inherited words of great antiquity, and have also created others of more recent origin. An estimated 75% of the present medical English can be traced to the Greek of Hippocrates who was born about

480 B.C. Approximately 25% of the words in the medical dictionary are formed with the aid of a prefix or a suffix — indicating their importance.

There has been recent criticism of physician who lack skills in communicating effectively with their patients. For example, take a nice, uncomplicated word like "whiplash" and you'll find that some doctors fancy it up so that it comes out "cervical acceleration extension injury" — complicated terminology.

Stroke and Bedwetting

Or, rather than use the term "stroke," doctors may talk about "carotid artery occlusive disease" or a "cerebral vascular accident."

In the same vein, bedwetting becomes "enuresis" . . . a heart attack is a "myocardial infarction" . . . a sore throat is "pharyngitis" . . . a bruise is described as "hematoma" . . . a headache is called "cephalagia" . . . and even common hiccupping is known as "singultus."

We believe that the language comparisons in the tables of this article will be helpful to practicing pharmacists.

PREFIXES

PREFIX	MEANING	EXAMPLE	DEFINITION
AB (L).....	Draw away	Abductor	Draw away from common center, as a muscle
AMBI (G).....	Both	Ambivalence	Opposing drives in emotion; love and hatred in the same person
ANTI (G).....	Against	Antipyretic	Drug that reduces fever
BI (L).....	Twice	Biceps	Two-headed
CONTRA (L).....	Against	Contraception	Prevention of conception
DYS (G).....	Difficult	Dysphagia	Difficult swallowing
ECTO (G).....	Outer	Ectopic pregnancy	Gestation outside of uterine cavity
ENDO (G).....	Within	Endometrium	Mucous membrane lining the inner surface of the uterus
HEMI (G).....	Half	Hemiplegia	Paralysis of half of the body
HYPO (G).....	Under	Hypodermic	Under the skin
INFRA (L).....	Within	Intromission	Insertion of one part into the other
KATA or CATA (G).....	Down	Catabolic	Destructive metabolism
META (G).....	Casting	Metabolism	Tissue change or production
OB (L).....	Inversely	Obstruent	Causing blockage
PERI (G).....	Around	Periostitis	Inflammation of the periosteum
RETRO (L).....	Backward	Retroversion	Turning back; for example, of the uterus
SEMI (L).....	Half	Semicoma	Mild degree of coma
SUB (L).....	Under	Subcostal	Beneath the ribs
SYM or SYN.....	Together	Synarthrosis	An immovable joint
TRANS (L).....	Through	Transurethral	Through the urethra
ULTRA (L).....	Excess	Ultramicroscopic	Too small to be seen with the regular microscope

SUFFIXES

SUFFIX	MEANING	EXAMPLE	DEFINITION
-ALGIA (G).....	Pain	Nephralgia	Kidney pain
-CELE (G).....	Protrusion	Gastrocele	Hernia of stomach
-CENTESIS (G).....	Puncture	Paracentesis	Puncture of cavity
-DESIS (G).....	Fixation	Arthrodesis	Surgical fixation of a joint
-ECTASIS (G).....	Dilation	Angiectasis	Abnormal dilation of a blood vessel
ECTOMY (G).....	Excision	Oophorectomy	Removal of an ovary
-ITIS (G).....	Inflammation	Carditis	Inflammation of the heart
-MALATIS (G).....	Softening	Osteomalacia	Softening of the bones
-MEGALY (G).....	Enlargement	Splenomegaly	Enlargement of the spleen
-OMA (G).....	Tumor	Adenoma	A glandular tumor
-PATHY (G).....	Disease	Myopathy	A disease of the muscle
-PTOSIS (G).....	Prolapse	Blepharoptosis	Drooping of the eyelid
-PLASTY (G).....	Plastic repair	Arthroplasty	Repair of a joint
-STOMY (G).....	Creation of an opening	Cystostomy	Creating an opening from urinary bladder through the abdomen
-TRIPSY (G).....	Crush or grind	Lithotripsy	Crushing of a calculus (stone) in the bladder or urethra

(G) = Greek (L) = Latin

This article is reprinted with permission from the January, 1981 issue of *Pharmacy Times*. Dr. Provenza is a member of the MPhA.

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INDUSTRY RELATIONS COMMITTEE asks that Association members contact the Committee with information and examples of products that present dispensing difficulties. For example: package or container too small to label without covering necessary information; or product dilution information confusing or not legible, etc. The Committee will research the problem and may submit it to the USP and FDA's drug problem reporting system for correction. Call the office — (301) 727-0746.

EMPLOYER/EMPLOYEE RELATIONS COMMITTEE is reactivating and looking for new members. Do you have a problem with your employer or employee? Are you being mistreated and wonder what your rights are? The Committee offers a forum for the exchange of ideas and solutions. Contact the Association office — (301) 727-0746 if you have a question or would like to volunteer for this important M.Ph.A. Committee.

PSF INVOLVED IN COMPUTERIZATION

PSF (Pharmaceutical Services Foundation of Maryland) is involved in the conversion of its processing of prescription claims to electronic data processing. Upon completion of computerization detailed information will be provided PSF members and pharmacy owners interested in participating.

Bessie Myers

Died April 1, 1981 — age 97

The Mother of five Pharmacists.
Ellis, Charles, Irving, Morton and Bernard



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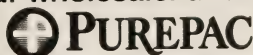
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<input type="checkbox"/> Alcohol (Isopropyl) 91% 8 oz.	<input type="checkbox"/> Hinkle's Tablets, Plain 100's
<input type="checkbox"/> Alum Powder NF 2 oz. 3.5 oz. Pound	<input type="checkbox"/> Hydrogen Peroxide 10 Vol., USP 4 oz. 8 oz. Pint Gallon
<input type="checkbox"/> Ammonia, Arom. Spts NF 1 oz. 2 oz. Pint	<input type="checkbox"/> Ichthammol Ointment, NF 10% 1 oz. 20% 1 oz.
<input type="checkbox"/> Analgesic Balm 1 oz.	<input type="checkbox"/> Iodides, Tincture 1 oz. Pint
<input type="checkbox"/> APC Tablets 100 1000	<input type="checkbox"/> Iodine, 2% Tincture, USP 1/2 oz. 1 oz. Pint Gallon
<input type="checkbox"/> Aspirin Tablets, USP 100 250 1000	<input type="checkbox"/> Iodine, 7% Tincture 1 oz. Pint Gallon
<input type="checkbox"/> Bacitracin Ointment, USP 1/2 oz. 1 oz.	<input type="checkbox"/> Iodine Solution Strong (Lugol's), USP (Rx) Pint
<input type="checkbox"/> Bay Rum 8 oz. Pint	<input type="checkbox"/> Ipecac, Syrup, USP 1 oz.
<input type="checkbox"/> Beef, Iron & Wine Pint	<input type="checkbox"/> Kaolin and Pectin Pint
<input type="checkbox"/> Belladonna Alkaloids w/Phenobarbital Elixir (Rx) Pint	<input type="checkbox"/> Mercurochrome 1/2 oz. 1 oz.
<input type="checkbox"/> Benzoin Compound, Tinc., USP 1 oz. 2 oz. Pint Gallon	<input type="checkbox"/> Merthiolate, Tincture (Lilly) 1/2 oz. 1 oz.
<input type="checkbox"/> Blue Stone (Cup. Sulf. Tech.) 4 oz.	<input type="checkbox"/> Milk of Magnesia, USP Pint Quart Gallon
<input type="checkbox"/> Boric Acid Granules, NF 2 oz. 4 oz.	<input type="checkbox"/> Mineral Oil - Light, NF Pint Gallon
<input type="checkbox"/> Boric Acid Ointment 1 oz. 2 oz.	<input type="checkbox"/> Mineral Oil - Heavy Pint Gallon
<input type="checkbox"/> Boric Acid Powder, NF 2 oz. 4 oz. 8 oz. Pound	<input type="checkbox"/> Mineral Oil - Extra Heavy Pint
<input type="checkbox"/> Brown Mixture 4 oz. Pint	<input type="checkbox"/> Olive Oil, USP 2 oz. 4 oz. Pint
<input type="checkbox"/> Burrow's Solution 8 oz. Pint	<input type="checkbox"/> Orris Root 2.5 oz.
<input type="checkbox"/> Calamine Lotion, Plain, USP 4 oz. 8 oz. Pint	<input type="checkbox"/> Oxalic Acid, Crystals 1 oz.
<input type="checkbox"/> Calamine Lotion, Phenol, USP 4 oz. 8 oz.	<input type="checkbox"/> Paregoric, USP (Rx) Pint Gallon
<input type="checkbox"/> Camphor, Spirit, NF 1 oz. 2 oz.	<input type="checkbox"/> Peppermint, Spirit, NF 1 oz.
<input type="checkbox"/> Camphor Liniment 2 oz. 4 oz.	<input type="checkbox"/> Phenobarbital Elixir, USP (Rx) Pint Gallon
<input type="checkbox"/> Cascara Sagrada, Fl. Ext., USP 18% Arom 4 oz. Pint	<input type="checkbox"/> Rochelle Salt 2 oz.
<input type="checkbox"/> Cascara Tablets, NF Choc. Ctd. 5 gr 100's	<input type="checkbox"/> Rhubarb & Soda Mixture 4 oz. Pint
<input type="checkbox"/> Castor Oil, USP (Tasteless-Odorless) 2 oz. 4 oz. Pint	<input type="checkbox"/> Rolox Suspension (Antacid) 12 oz. Gallon
<input type="checkbox"/> Catnip and Fennel Elixir 4 oz.	<input type="checkbox"/> Saccharin Tablets - Sweetest* 1000's 1/4 Gr. 1/2 Gr. 1 Gr.
<input type="checkbox"/> Catnip Herb 1 oz.	<input type="checkbox"/> Salicylic Acid, USP 1 oz.
<input type="checkbox"/> Chamomile (Hungarian) 1 oz. 2 oz.	<input type="checkbox"/> Saltpeter 2 oz. 4 oz. Pound
<input type="checkbox"/> Cherry Syrup, NF Pint	<input type="checkbox"/> Senna Comp. Powder 2 oz.
<input type="checkbox"/> Citronella, Oil of (True Ceylon) 1 oz. 2 oz.	<input type="checkbox"/> Senna Leaves, NF 1 oz.
<input type="checkbox"/> Cloves, Oil of 1 dram	<input type="checkbox"/> Soda Mint Tablets 100's
<input type="checkbox"/> Coal Tar Solution, USP Pint	<input type="checkbox"/> Sodium Bicarbonate, USP 4 oz. Pound
<input type="checkbox"/> Cod Liver Oil, USP Norwegian, Plain Pint	<input type="checkbox"/> Sodium Bicarb., Tab., USP 10 Gr. 100's
<input type="checkbox"/> Cold Sore Lotion 1/2 oz.	<input type="checkbox"/> Salt Tablets 100
<input type="checkbox"/> Cream of Tartar 2 oz.	<input type="checkbox"/> Salt Tablets w/Dextrose 100
<input type="checkbox"/> Dental Plaster (Plaster Paris) 4 oz.	<input type="checkbox"/> Sulfur, NF, Sublimed 2 oz. 4 oz. 8 oz. Pound
<input type="checkbox"/> Dextrose Pound	<input type="checkbox"/> Sulfur & Cream of Tartar Lozenges 36's
<input type="checkbox"/> Diphenhydramine HCl Elixir (Rx) Pint	<input type="checkbox"/> Sweet Oil (Olive Oil), USP 1 oz. 2 oz.
<input type="checkbox"/> Dobell's Solution Pint	<input type="checkbox"/> Terpin Hydrate, Elixir, NF Pint Gallon
<input type="checkbox"/> Epsom Salt (now Magnesium Sulfate, USP) 5 oz. 8 oz. Pound 4 lbs. 5 lbs.	<input type="checkbox"/> Terpin Hydrate & Codeine, Elixir, NF 2 oz. 4 oz. Pint Gallon
<input type="checkbox"/> Eucalyptus, Oil of, NF 1 oz. 2 oz.	<input type="checkbox"/> Terpin Hydrate and Dextromethorphan Elixir, NF 4 oz.
<input type="checkbox"/> Fullers Earth 2 oz.	<input type="checkbox"/> Turpentine, Spirits 2 oz. 4 oz.
<input type="checkbox"/> Gentian Violet Solution 1% USP 1 oz.	<input type="checkbox"/> Whitfield's Ointment 1 oz. Pound
<input type="checkbox"/> Gentian Violet Solution 2% 1 oz.	<input type="checkbox"/> Wintergreen, Oil 1 oz. 2 oz. 4 oz.
<input type="checkbox"/> Glycerine, USP 1 oz. 2 oz. 4 oz. Pint	<input type="checkbox"/> Witch Hazel, Dist., Extr. 8 oz. Pint
<input type="checkbox"/> Glycerine & Rose Water 4 oz.	<input type="checkbox"/> Zinc Oxide Ointment, USP 1 oz. 2 oz.

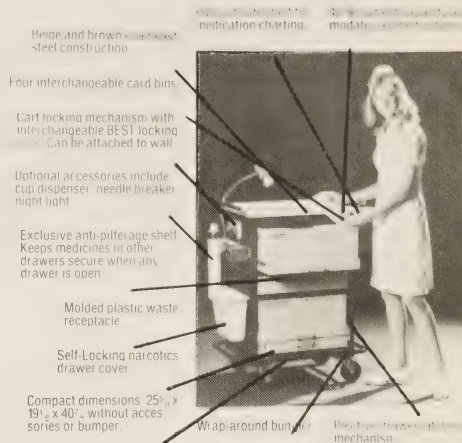
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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS,
published by the St. Louis College of Pharmacy;
Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

PERIPHERAL VASCULAR DISEASE:

Peripheral vascular disease has occasionally responded to surgical intervention, but the effect of drug therapy has been less dramatic. It has been suggested that withdrawal from vasoconstrictors and cessation of smoking will do more to correct problems with peripheral perfusion than using "vasodilator therapy". Ethanol will dilate vessels, but only those which are non-occluded. However, ethanol in small amount may help protect against vascular disease and could possibly help offset the effects of smoking. *BR MED J*, Vol. 281, #6234, p. 794, 1980.

OTITIS MEDIA:

Approximately 30 million people will visit physicians of-fices this winter complaining of otitis media caused by either Hemophilus influenzae or Streptococcus pneumonia. Approximately 10% to 20% of the H. influenzae organisms are now resistant to ampicillin so other drugs are needed to control these infections. One pediatrician found some benefit by using a single daily dose of sulfamethoxazole (taken at bedtime) as a prophylactic. Cefaclor (Ceclor) has been found to be effective when ampicillin resistance is encountered, but it is no more effective than ampicillin in organisms sensitive to the penicillin derivatives. Since otitis media is especially common in children, investigators feel that a vaccine may be the ideal way to protect patients against this disease. Some genetic factors may be involved because retrospective studies show that there is a lower incidence of this condition in Balcks while the Australian aborigines, the American Indians, and the Alaskan Eskimos have a significantly higher incidence of the disease. *J AM MED A*, Vol. 244, #20, p. 2243, 1980.

BOARD CERTIFICATION OF PHYSICIANS:

Because there has been an increase in the number of board certified physicians in this country, more of them are turning to establishment of a practice in smaller communities. This results in better care for patients in areas where serious problems were usually referred to physicians at some distance. Some physicians apparently are enjoying the opportunity to live and work in non-urban areas. *N ENG J MED*, Vol. 303, #18, p. 1032, 1980.

CALCIUM ANTAGONISTS:

Four drugs have been found to block the entrance of calcium into the cell and thus may have potential application in the treatment of various cardiovascular diseases. The agents being used most widely in an experimental capacity include nifedipine, verapamil, diltiazem, and perhexiline. The drugs are all well absorbed after oral administration, are highly protein bound, and have half-lives in the plasma of approximately four hours. *ANN INT MED*, Vol. 93, #6, p. 886, 1980.

ECT AND DIABETES MELLITUS:

Diabetic patients receiving electroconvulsive shock therapy (ECT) have occasionally been noted to experience an improvement or remission in their intolerance to glucose. A group of 14 patients receiving this therapy were monitored to see if there was an improvement in their diabetic state after CET therapy. Eight patients experienced complete remission in their diabetic condition. Those who benefited most were patients who recently experienced the onset of non-insulin dependent diabetes mellitus. *LANCET*, Vol. II, #8198, p. 775, 1980.

ANTIFUNGAL THERAPY:

A new investigational drug, ketoconazole, has been found to be very effective when given orally to treat patients with both superficial and disseminated fungal infections. Patients who had suffered from fungal infections over 6 years were helped by administration of the drug. Ketoconazole was discovered during anti-fungal screening of several imidazole derivatives. *J AM MED A*, Vol. 244, #18, p. 2019, 1980.

DIGOXIN SENSITIVITY:

Infants require comparably higher doses of digoxin (Lanoxin) in order to experience the same therapeutic effect as seen in adults. The average maintenance dose for adults is 3 to 5 ug/Kg/day, while infants require from 10 to 25 mg ug/Kg/day. The extent of absorptions is identical in both groups, but the glycoside apparently is capable of binding to infants erythrocytes in amounts 2.5 times greater than is observed with adult cells. This can help account for the need for higher doses in infants. *CLIN PHARM*, Vol. 28, #3, p. 346, 1980.

DIABETES MELLITUS AND IMPOTENCE:

A high percentage of patients with overt diabetes mellitus complain of sexual impotence. In fact, it has been discovered that approximately 12.1% of the patients who complain of impotence actually have diabetes mellitus without showing the characteristic signs of the disease. Patients presenting with symptoms of impotence might be given a glucose tolerance test to determine the blood sugar status. *J AM MED A*, Vol. 244, #21, p. 2430, 1980.

PHENYTOIN:

The effect of phenytoin on the kidney has recently been studied to determine what alterations in renal activity might occur during phenytoin therapy. Infusion of the drug directly into the renal artery causes vasodilation, diuresis, and naturesis in spite of renin release. *J PHARM EXP*, Vol. 215, #2, p. 304, 1980.

ANTACID TOXICITY:

Patients who routinely ingest aluminum hydroxide-containing antacids may experience musculoskeletal pain due to the decrease in phosphate absorption produced by excessive aluminum ingestion. It has been estimated that 16.7 grams of aluminum hydroxide can bind one gram of phosphate, the average amount found in the daily diet. Phosphate depletion can lead to the production of osteomalacia and musculoskeletal pain. Symptoms are especially evident in the elderly patient. A clinician has suggested that calcium-containing antacids should be considered as replacements for the aluminium-magnesium containing antacids. *J AM MED A*, Vol. 244, #33, p. 2544, 1980.

Classified Ads



Classified ads are a complimentary service for members.

Available from the MPhA Office

- Notification for the patient under the Drug Product Selection Law
- Heart Shaped Stickers — no charge
- Information on the Blue Cross/Blue Shield Major Medical Health Insurance Program
- The Association's Employment Clearinghouse, helping pharmacists and employers find one another
- I.C. collection help
- Information on the NEW USP/NF on sale from MPhA.

For these and many other services, contact Sharon at the MPhA Office. (301) 727-0746

The University of Maryland School of Pharmacy is interested in including 4 antique pharmacy fixtures in its new building, planned for completion in 1983. Anyone interested in such an idea is invited to call the Dean's Office, 528-7650.

Pharmacy space in a medical building coming in late 1981 on Reisterstown Road in Owings Mills (across 1500 units apartment complexes). Suites will be condominiumized for sale or lease. Call evenings 744-0675.

The 16th Annual Maryland Society of Hospital Pharmacists Seminar will be held at the Carousel Hotel in Ocean City, Maryland on June 19, 20 and 21. The theme of this year's seminar will be Communications/Emergency Medicine. For more information please contact Robert Tonelli c/o U.S. Public Health Service Hospital, 3100 Wyman Park Drive, Baltimore, Maryland 21211.

Pharmacy for Sale. Hagerstown. Established in neighborhood 19 years. Owner re-located. Excellent opportunity for one-man operation. Lease available. Must sacrifice with extremely low cost for early sale. For full particulars, phone (301) 797-3603, evenings after 7:30.

Any Pharmacy having sulfathalidine (discontinued by MSD) please contact Frank Tamberino at Highland Pharmacy 327-8712. Urgently needed for Patient.

Gentlemen owning a 90 year old pharmacy in the Butcher Hill area seeking registered pharmacist as partner. Contact Mr. Sheldon Rosoff at 655-7296 or leave message at 833-2080.

The Elder Ed program has developed the following brochures for older consumers: "Sublingual Nitroglycerin Tablets, some do's and don'ts", "Vitamins are not Enough!", "How to Select Your Pharmacy", and "You and Your Medicines". For additional information contact Elder Ed at (301) 528-3243.

A free brochure listing all tapes for the TELMED program is available. Call 528-6294 or write the office of the Director, University of Maryland Hospital, 22 South Greene St., Baltimore, 21201.

Alumni of the Philadelphia College of Pharmacy and Friends will have a breakfast at the M.Ph.A.-Delaware joint Convention in Ocean City on Tuesday, June 23, 1981 at 8:30 a.m.

Hotline for impaired Physicians (301) 467-4224

Hotline for impaired Dentists (301) 796-8441

During 1982, the Centennial Committee will supply the *Maryland Pharmacist* with lists of important Maryland pharmacists for publication in the monthly journal. The obvious will be included: the presidents of MPhA, the deans of Maryland, the heads of national organizations, the board members, plus certain individuals who are noted for their accomplishments. Help the Committee by suggesting additional categories or specific people and send your information to the Committee.

Recent graduate wanted to work at established community pharmacy with outlook toward future ownership. Contact Box 10.

Graduating pharmacy student desires full-time position in independent pharmacy — mature, responsible. Resume and references on request. Box 7 MPhA Office, 650 W. Lombard St., 21201.

Part time help wanted in active community store in Baltimore. Flexible schedule. Contact Box 15, MPhA office, 650 W. Lombard St., Baltimore 21201.

calendar



MAY 4-6 — NARD Legislative conference, Washington

MAY 4 — ASHP Regional Conference, Baltimore

MAY 7 8 MPhA Board of Trustees meeting, Kelly Building

MAY 13 — Alumni Annual Meeting, Student Union Bldg. 9 P.M.

MAY 14 — MSHP Symposium, Union Memorial Hospital 4 P.M.

MAY 28 — Alumni Graduation Banquet, Eudowood 6 P.M.

JUNE 19-21 — MSHP Annual Convention, Carousel, Ocean City

JUNE 21-25 — MPhA CONVENTION — CAROUSEL HOTEL OCEAN CITY (Reminder: reservation deadline — May 23rd!!!)

SEPT. 17-25 — MPhA TRIP TO IRELAND \$599 up — Dublin, Limerick, Killarney — call office for details

SEPT. 20-24 — NARD Convention — San Antonio

Every Sunday Morning at 6:15 a.m. listen to Charles Spigelmire on WCAO broadcast the Pharmacy Public Relations Program "Your Good Neighbor," the oldest continuous public service show in Baltimore.

99th MARYLAND PHARMACEUTICAL ASSOCIATION

JOINT ANNUAL CONVENTION

Maryland Pharmaceutical Association

Delaware Pharmaceutical Society

MPA ————— Let's get together! ————— 

June 21-25, 1981
OCEAN CITY, MARYLAND

SUNDAY
June 21

9:30 p.m.

Registration open at 12:00 Noon (rooms available at 3:00 p.m.)
Tennis, Golf, Swimming & Ice Skating
Welcome Cocktail Party (joint with Delaware)

MONDAY
June 22

9:00 a.m.
to
noon

"Pain Management" — C.E. Program (joint with Delaware)
Lampa — Brunch Meeting and Fashion Show

6:30 p.m.

*Crabfeast and chicken at Berlin Fire Hall —
Square Dance (joint with Delaware)*

TUESDAY
June 23

9:30 a.m.
to
noon

Open General Session — House of Delegates
First Session — Officers Reports
Lampa Board Meeting

WEDNESDAY
June 24

9:00 a.m.
to
noon

House of Delegates — Second Session
Election of Nominees to Board of Pharmacy
Nomination of Officers and Trustees for
Mail Ballot

6:00 p.m.

*Cocktail party — Annual MPhA Banquet Awards
and installation of Officers with special program*

THURSDAY
June 25

9:00 a.m.

"Estate Planning" by John T. Rogers, certified
financial planner — Legg Mason Wood Walker Inc.
(a Simon Solomon Seminar)

MPHA CONVENTION



at
the
Carousel

OCEAN CITY, MARYLAND
JUNE 21-25, 1981

THE MARYLAND PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

June, 1981
VOL 57
NO. 6



1981 State Legislative Wrap-up

Building Sales to Younger Customers

A.Ph.A. Shaping Pharmacy's Future

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
TELEPHONE 301/727-0746



JUNE, 1981

VOL. 57

NO. 6

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DAVID A. BANTA, *Editor*
SHARON SPIES, *Assistant Editor*
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GUEST MESSAGE

As incoming President of the Maryland Society of Hospital Pharmacists, I am pleased to have been asked to address the Maryland Pharmaceutical Association through this editorial.

For me, the year ahead is both a professional and a personal challenge.

Professionally, to guide the MSHP through the issues that will face our Society in the coming year will require the input and support of all facets of our profession. Within our Society, many members have the experience, knowledge, and background to provide necessary input and assistance. However, in many instances, particularly on issues that may be broader in scope than that which affects our membership, it will be necessary to seek the input and opinions of the leadership of the Maryland Pharmaceutical Association, as well as other voices of our profession. The degree of cooperation which has developed in recent years between the MSHP and MPhA will make this part of my responsibility one to be anticipated with optimism. I pledge to continue the understanding, respect and cooperation which exists between our two organizations, especially on the matters of legislative issues and continuing education efforts.

This year will also be a personal challenge for me, to continue in the footsteps of our Society's previous leaders who have created and achieved meaningful and significant goals for the Society during their team of office. Through the dedication of the members of the Board of Directors, the committee chairmen and other volunteer members, I hope to complete the tasks identified as goals for 1981-82. This will include the creation of a MSHP Procedure Manual, designed to facilitate the transition and communication from year to year.

I thank the MPhA for this opportunity to introduce myself to your membership, and I look forward to the year ahead.

William R. Grove
President-Elect
MSHP

1981 Legislature Wrap-up

The Work of the Maryland Pharmaceutical Association in the area of government relations is perhaps the most vital function of the Association on behalf of all pharmacists; whether they are members or not. It is true, unfortunately, that even non-members of the Association benefit whenever the Association is successful in its lobbying efforts to the extent that the practice of pharmacy is enhanced for all pharmacists. The Association, in effect, represents all pharmacists when testimony is presented before legislative committees, when interviews are conducted with the news media, and when position papers are provided to important government regulatory agencies.

The Association works in conjunction with a number of other lobbying groups such as the Medical Society and other allied health care professions, the association of chain stores, manufacturing interests, insurance companies, proprietary and business interests, and others. As the Association begins to take a position on legislative issues, it coordinates its view and testimony with several other groups within pharmacy such as the Board of Pharmacy, the School of Pharmacy, the Maryland Society of Hospital Pharmacists, the Maryland Chapter of the American Society of Consulting Pharmacists and others to ensure that the voice of pharmacy can be presented in as unified fashion as is possible.

The legislative work of the Association is conducted by the Legislative Committee, under the Chair of Milton Sappe. Working with Executive Director David Banta, who is also the Association's registered lobbyist, the Committee gets its general policy direction from appropriate resolutions of the House of Delegates. Early each Fall, the Committee suggests a legislative platform of positions on issues and proposed bills which are then subsequently ratified by the Board of Trustees. The Committee monitors the legislative process while the General Assembly is in session and makes decisions regarding revised policy as the need develops. Banta

monitors the work of the legislature on a daily basis. He develops, coordinates and presents testimony on the bills that are heard before legislative committees, including position papers when necessary. Occasionally, pharmacists are called upon to provide expert testimony on certain bills of a technical nature. Certain larger issues will call for a major showing of pharmacy support or opposition in the form of multiple witnesses or an organized telephone and letter campaign. These activities are coordinated by the Legislative Committee.

The Maryland Legislature acted upon the following bills affecting Pharmacy. Those that were passed must be signed by the Governor in order to be enacted into law. This list is a summary of the more important bills that the Committee followed.

BILLS THAT PASSED

HB 1215 This bill passed in the final hours of the session and repeals the "ineffective" drug list under the Medicaid program. It was a major effort of the Association's lobbying goals working with a coalition of other health interests for passage. Pending the Governor's signature, it is expected that on July 1, 1981, the Medicaid "ineffective" drugs, which had been ineligible for reimbursement by the program, will be restored.

HB 1 This bill passed and has been signed by the Governor. It is a complete updating of the Pharmacy Practices Act as other health occupation laws. The Association suggested three amendments to the bill to improve it and all were adopted. This Bill represents nearly 4 years of work by the Governor's Code Commission to rewrite the Health Care Article with help from the Association and other resources within pharmacy.

HB 76 This bill merely deletes some obsolete language in the Medicaid program which had set up the old Positive Formulary before our current Drug Product Selection law was adopted.



HB 77 This bill adds the attempt to obtain a drug by forged prescription under the Medicaid program to the definition of "Fraud"

HB 132 It allows the Board of Pharmacy to collect disciplinary fines as another alternative to suspension or revocation of a pharmacist's license.

HB 1712 It provides for an exemption for most of the faculty members of the University, and Board of Pharmacy members from the requirement in the Ethics Law for a financial disclosure statement.

SB 107 It sets up the "Golden Card" which will be given by the Department of Aging to senior citizens who will use them to obtain retail discounts which the Department will encourage.

SB 278 This bill increases slightly the eligibility limits for participation in the state-funded Pharmacy Assistance program. It should result in more participants in this small pharmacy program.

BILLS THAT FAILED BUT WERE ASSIGNED TO SUMMER STUDY

SB 933 This bill was a major effort of the Legislative Committee for the 1981 session. It sought to improve the conditions of the Pharmacy third party contracts, by requiring some minimum conditions. It called for "usual and customary" reimbursement and recognition of an administrative fee. The Bill was passed by the Senate Committee but incurred opposition from "labor" and other groups. It was referred to the Committee for further study this summer. Many Association members worked individually on this bill by contacting their legislators in person or by telephone. This issue will continue to be a major effort of the Committee.

HB 701 This bill would require that some form of identifying mark be placed on all tablets and capsules marketed in Maryland so that pharmacists and the Poison Control Center can more easily identify some drug products outside of the prescription container.

BILLS THAT FAILED

HB 136 This bill would have allowed the Maryland Positive Formulary to automatically adopt drugs appearing on the FDA's list of therapeutic equivalents without an administrative hearing.

HB 236 This Association supported bill would have increased the penalties for illegal possession of a handgun. It failed shortly before President Reagan was shot.

HB 392 The Optometrists supported this bill which was lost in the last few hours of the session. It would allow them to use certain diagnostic drugs in their practice and was opposed by the Medical Society and the Optomologists.

HB 451 This bill would have cut the time limit for submitting a claim to the Medicaid program from 12 months to 6 months after the service had been provided.

HB 405 This bill would have allowed the Board of Pharmacy to raise certain non-pharmacist licensing fees.

HB 546 This Association backed bill would repeal the mandatory price poster for pharmacists. It was passed out of two committees of the house only to die when they could



not agree to concur on an amendment saying that pharmacists would give prices over the telephone.

HB 571 This bill would have required that all retail outlets that sell needles and syringes keep a registry as pharmacists are now required to.

HB 625 This Board of Pharmacy proposed Bill would have restricted the entranceways into nursing homes that had pharmacies open to the public.

HB 1031 This bill would have made "overcharging" for professional services grounds for disciplinary action by the Board of Pharmacy.

HB 1363 This Bill would have required that the sale of DMSO be regulated by the Board of Pharmacy.

HB 1407 The Association supported this bill which would have added a limited OTC formulary to coverage under the Medicaid program.

HB 1521 This Bill would have licensed dispensing physicians under the Board of Pharmacy.

HB 1539 This bill would have raised the individual license fee for pharmacists from \$15.00 to \$50.00 but the Board of Pharmacy would have received the increased revenue for its budget.

HB 1903 This bill added "nurse practitioners and nurse midwives" to the definition of authorized prescribers under the pharmacy law. It also would have allowed them to dispense their prescriptions.

SB 65 The use of information obtained from lie detector tests was the subject of this bill.

SB 78 This bill would have allowed physicians to use Marijuana in the treatment of glaucoma. We were not sure where the prescriptions would be filled.

SB 450 This bill would have mandated that pharmacists keep a patient profile system. The Association supports the use of patient profiles as a standard of practice and has worked to encourage pharmacists in this area, however, it did oppose this bill.

This brief summary should give members an idea of the variety of subjects considered by the Legislature and the important work that the Legislative Committee does for all pharmacists. Any member who would like additional information concerning these bills or who would like to become more involved with the work of the Committee should contact the Association office.

From the M.Ph.A. Legislative Committee: Heres what you can do to he



REGISTRATION AND VOTING

1. Register to vote and encourage family and friends to register also.
2. Check out absentee registration rules with your local registrar if you are out of town frequently.
3. Vote in primary and general elections and encourage family and friends to vote also.
4. Vote by absentee ballot if you are going to be out of town.

PARTY AND CAMPAIGN ORGANIZATION

1. Get active in a political party of your choice.
2. Serve on a political party committee.
3. Work on a candidate's campaign committee.
4. Volunteer to:
 - a. help a candidate or party address and stuff envelopes
 - b. distribute campaign literature in your neighborhood
 - c. prepare voter index cards and lists for campaigns
 - d. work in a phone bank to recruit other party workers or get people out to vote on Election Day
 - e. organize rallies and fund-raising events
 - f. type letters
 - g. act as a poll watcher
 - h. host a coffee/tea party for a candidate
 - i. design campaign posters and ads
 - j. give rides to the polls
 - k. be a precinct worker or a block captain

WHY WRITE A PUBLIC OFFICIAL?

"Write your Congressman" is the proverbial advice given when someone complains about what Government has done, is doing, or is about to do. And, often the response is "Why bother, it won't make any difference anyway." On the contrary, it can and does make a difference.

Next to voting, writing a Member of the House, U.S. Senator, governor, state legislator or mayor is one of the most important ways a citizen can participate in our democratic system. The mail that public officials receive provides an indispensable link to the public official to deal with your request.

- **Try to be brief.** Certainly, you should take the time to explain your views and avoid gaps in your explanation. However, a long letter is likely to be set aside to be read when "there is more time," thus delaying any anticipated action by the public official. Try to keep your letter to one page or two pages at the most. If it must be longer, perhaps you should arrange to see the official in person to discuss the matter.

Don't overlook telegrams or telephone calls when time is short.

- **Get to the point.** It is best to summarize your position or problem in the first paragraph, using the balance of the letter to explain your views. This technique will help the officeholder and his staff more quickly identify why you are writing and help them expedite dealing with your request.

- **Be factual.** Avoid using arguments that cannot be substantiated with facts. You will hurt your credibility in future dealings you may have with the officeholder.
- **Personalize your message.** If you're writing about a legislative proposal, explain how it affects you or your business. It is difficult for a public official to base his decisions on abstractions. Give examples that illustrate your viewpoint.
- **Give essential background information.** Explain something about the background of your problem or concern. The official may not know as much about the matter as you. Also, if you have dealt with another official on the matter, mention so in your letter. The public official you are writing may wish to coordinate his activities with the first official.
- **Be positive.** Don't make a request of an official in a negative or hostile tone. Write him with an open mind and he will be more likely to deal with you in a similar manner.
- **Use proper references.** If writing about legislation, refer to the bill number and the subject to which it pertains. Often there is more than one measure dealing with a particular subject. Writing that you're "against that tax bill" will not necessarily be meaningful information to your Congressman or state legislator.

Asthma Update

- l. write campaign material
- m. babysit for voters with small children on Election Day
- o. decorate meeting halls
- p. help publicize campaign and party events through the media

FUNDRAISING

1. Contribute financially to a political party or candidate and solicit funds from others.
2. Volunteer your services to provide expertise in election laws, accounting, fund-raising, marketing and promotion.

SUBSTANTIVE ACTIVITIES

1. Keep informed on vital issues facing the community and government.
2. Know the candidates and their qualifications.
3. Attend meetings of the city council, school board, or other public boards.
4. Communicate on issues with your elected representatives — local, state and national.
5. Write letters to the editor stating your position on a particular issue.
6. Hold appointive or elective office in government.

- **Don't use threats.** If someone wrote you asking that you consider a certain viewpoint or help with a particular problem, and then closed the letter by threatening to "get you if you don't come through for me," you probably wouldn't be very sympathetic to the request. Don't expect an officeholder to react any differently.
- **Clearly identify yourself.** If you are writing in an official capacity with your Company, indicate so. If you instead are writing as a private citizen, likewise indicate so and give your home address. In either case, be sure a return address appears on the letter in case the envelope is discarded. The use of Company stationery to express noncompany views and problems is a matter best left to individual Company policy.

Allergic diseases are among the most common and costly health problems facing Americans in the 1980s. A Task Force of the National Institute of Allergy and Infectious Diseases reported in 1979 that some 8.9 million Americans suffer from asthma, with or without accompanying allergies. The figure translates to four percent of the country's entire population who were afflicted with the disease at the time of the survey and does not include individuals who had the condition in the past and have since "recovered." Approximately seven percent of all Americans have had asthma at some point in their lives.

Considering that such a large segment of the population is affected by asthma, it is remarkable that the affliction has avoided the spotlight of public scrutiny. This lack of awareness is particularly due to the continuing inability to identify with certainty the fundamental disturbance of anatomy or physiology which express itself by attacks of asthma. Until such an answer emerges, asthma will be impossible to completely define and the mere description of the disease will have to suffice.

Asthma is an allergic condition characterized by a sudden narrowing (motion) of the bronchi, among with wheezing, coughing, mucous sputum, and difficulty in exhaling air. Extrinsic (allergy-induced) asthma usually begins in the first four decades of life; intrinsic (nonallergic) asthma may occur at any age, but most commonly after the age of forty. The prevalence of asthma is slightly higher in children than in adults. It is not known precisely how many people actually succumb to asthma because mortality figures vary according to the disease classification rubrics and statistical methods used. However, it is estimated that some 2000 to 4000 Americans die annually because of asthma.

Asthma is a chronic disease that affects virtually every facet of an individual patient's life. In addition, the economic impact of asthma is staggering. The total annual cost of allergic diseases, including asthma, has been put at well over \$1 billion and the figure does not include various disability benefits paid out each year. Medication costs alone are indicative of the scope of allergic diseases. According to 1975 drug industry estimates, \$224.2 million was spent on bronchodilators; \$24.7 million for corticosteroids; and \$43 million for over-the-counter asthma remedies.

Asthma also ranks among the leading causes of physician visits. The NIAID Report estimated that 27 million patient visits each year are for the treatment of asthma and in 1975 there were some 1.2 million first visits to private physicians because of asthma. To an individual family, bearing the cost of this severe disease can be financially devastating.



BUILDING SALES TO YOUNGER CUSTOMERS

By *S. E. Mahle*, President, S. E. Mahle Associates, Sales Training and Consulting for Retail Merchants, Winchester, Massachusetts



Younger customers are an important source of sales increases for two reasons. First, they are growing in numbers, and second, younger customers are consumers whose needs increase as they grow up, marry, and assume family responsibilities.

Two groups make up this market: (1) teenagers from 15-19, and (2) young adults from 20-24. Whether a small marketer can sell directly to the teenage group depends, to a great extent, on the type merchandise he offers. But even though not all can sell directly to them, some small marketers can increase their sales indirectly through the influence that teenagers exert on the family's purchases.

In building sales to younger customers it is helpful to know: what teenagers are like, what they expect from adults, and what changes take place as they finish school, marry, and have children of their own.

Two groups make up the younger customers. Some observers characterize one part of this market as boys and girls who "enjoy spending money." A frequent comment made by members of the other group is, "we need everything."

The first group of younger customers runs from about age 15 through 19. These teenage customers — boys and girls who "enjoy spending money" grow up into the second part of the younger customers market.

The second group — the "we need everything" consumers — consists of young adults from about age 20 through 24.

This Aid emphasizes the younger group because cultivation of these consumers can mean three things. First, some small marketers can increase their present sales by selling directly to teenagers. Second, other small marketers can increase their sales through the influence that teenagers exert on the family's spending. And third, in some cases, small marketers can build loyalty that will mean increased future sales — sales when these boys and girls grow into the young adult group.

TEENAGE BUYING POWER

Teenagers are a growing market. About 15 million of them are spending nearly \$10 billion a year. Indications are that by 1970 this group — 15 through 19 — will grow to about 19 million persons.

The average teenage income varies from \$10 to \$15 a week. In 1940, this weekly average was about \$2.50. In most cases, there are no strings attached to this income. It is 100 percent expendable because these boys and girls pay no taxes, insurance premiums, rent, or grocery bills. Their parents provide such necessities.

Furthermore, these young people like to spend their money. They also like to help their parents spend and exert a

tremendous influence on what the family buys.

For example: their opinions as to cars, furniture, appliances, TV sets, outdoor yard equipment, appliances, TV sets, outdoor yard equipment, and recreation accessories carry great weight in the spending of the family budget.

The extent to which the individual marketer can cash in on this market depends, of course, on his situation and his type business. It depends also on knowing something about teenagers and understanding some of the reasons why they buy as they do.

WHY TEENAGERS BUY

Four characteristics tend to make teenagers into fad buyers and impulse buyers. The average teenager is, in varying degrees: (1) self-centered, (2) a conformist, (3) materialistic, and (4) a pursuer of happiness.

• Self-Centered

Most teenagers are self-centered. One of the biggest reasons is that they are between childhood and adulthood.

Being acutely aware of themselves is part of the awkwardness of adolescence. However, since World War II, prosperity and an increasing number of teenagers has helped to make these young people even more aware of themselves, not only as individuals but also as a group.

• A Conformist

Although teenagers are self-centered, they are also conformists. They want to be part of their group.

In fact, most of them strive for conformity. They tend, to a great extent, to express their individuality as a group-individuality.

For instance, if football players wear a certain kind of shoes, the other students wear them too. The reason: They feel awkward and don't want to stand out as being different from their crowd.

• Materialistic

Material "things" are important to teenagers. Often they express themselves through such objects. For instance, a high school boy expresses his ability by rebuilding a jalopy. And many girls express their taste by collecting records.

This use of material objects for self-expression often spills over into the family. For example, the boy with the jalopy, in many cases, feels that the family car should be the latest model — one that indicates a successful father.

The importance which these young people place on material objects varies, of course, with individuals and various groups of teenagers. However, this material is important because, among other things, it is closely related to another facet of the teenage make-up — the pursuit of happiness.

● “The Pursuit of Happiness”

All age groups pursue happiness, but the teenage group tends to emphasize enjoyment more than some of the other groups. There's nothing wrong with this because many teenagers are serious workers in school, and some save part of their spare-time earnings for college expenses.

Often this enjoyment takes the form of using consumer goods, such as food. These boys and girls not only like to eat, but their growing bodies demand more calories — about 20 percent — than do those of adults. So many teenagers are in-between-meals eaters. They consume large amounts of hamburgers, hot dogs, candy, ice cream, and soft drinks.

These young people also like to be entertained. They like movies, television, radio music, records, and certain kinds of magazines.

This need for enjoyment, along with the need to conform, makes the average teenage buyer one who purchases on impulse. And many of his or her impulse purchases are fad items.

CULTIVATING TEENAGE CUSTOMERS

As with customers in other age groups, the first requirement in cultivating teenage customers is stocking goods that appeal to them. Not all small marketers can do this. For example, most teenagers aren't interested in buying vacuum cleaners, refrigerators, and other household furnishings.

But even so, if you carry lines, or can add lines, that appeal to this group, you may be wise to review what these boys and girls expect from adults — especially from merchants.

First, teenage buyers like to be treated as adults. They like to talk about *their* interests. They want to express their opinions and resent your referring to them as “kids.”

Second, they want to be catered to. They want to be waited on in their turn. They are more sensitive, in some cases, to being passed over than adults are.

Third, these buyers want fast service. They like to finish one things and move on to another. They quickly become impatient at unnecessary delays. For instance, slow speech sometimes makes them impatient so that merchants would be wise to talk a little faster than normal when addressing them.

Fourth, these boys and girls like personal recognition. If your operation is such that you know their names, speak to them by name in the store and on the street.

And finally, teenage buyers like informality. However, at times they are easily embarrassed. So don't say or do anything that might embarrass them or make them feel that you are intruding. And above all, resist the temptation to act as young as they are.

● Eight Specifics

Keeping in mind what teenagers are and what they expect as buyers there are at least eight specific things which small marketers can use to build sales to these younger customers. How many and exactly how you can use them depends, of course, on your situation.

(1) *Cultivate the leaders.* Sell teenage leaders — the athletes, cheerleaders, and class officers — and you improve your chances of selling to the group. Some retailers send such leaders a note of congratulation after an important game or other school event.

(2) *Use fashion panels.* If you sell clothing or other fashion merchandise, you may want to set up a student panel as a way of getting ideas about their opinions and tastes. Include some followers along with the leaders.

(3) *Attend their public functions.* In small communities and in locations with only one high school you may want to attend school events. If so, try to buy your tickets in advance. Buy from a different student each time, if you can, so you'll get to know more of them.

(4) *Advertise in high school publications.* Make your advertisement appealing to high school students.

(5) *School windows.* Some marketers feature school activities in their window displays. They show drawings, vocational arts work, and so on along with related merchandise. Windows can also be used for recognizing the athletic teams, cheerleaders, and officers of student organizations.

(6) *Offer part-time employment.* Some small retail establishments employ high school students on the weekends. Ice cream stores, soda shops, and other eating places frequented by teenagers are natural for this type employment.

(7) *Build a mailing list* of members of the junior and senior classes. Before Christmas, Father's Day, and Mother's Day send them a letter offering gift suggestions.

(8) *Send the class officers* flowers at Junior and Senior prom time — bouquets for the girls, boutonnieres for the boys.

If you sell items that this group will need in early adulthood, you will want to do one more thing. Each spring work up a list of the names and addresses of the graduating class. Use a care for each person so you can sort them later.

FOLLOWING TEENAGERS INTO ADULTHOOD

With graduation from high school, teenagers move into young adulthood pretty rapidly. Some of them go to work, some go to college, and some get married.

Going to Work. About 25 percent of the high school graduates across the country go to work. Now they are earning their own money on a full-time basis. Many of these young people stay at home — or close by — so you still have a good chance of selling to them. File your address cards for this group together.

Going to College. About 40 percent of those who finish high school throughout the country enter college. They'll buy things to take with them, and some of them may also buy from you when they're home on visits.

So when they're in town for holidays and vacations, remind them of your store. Use your card file and send them a card. Or in your advertisements invite them to come in and say hello.

Try to keep your store image before them because some of these young men and women will return home to work after college graduation. Often they become big earners and community leaders who can be among your best customers.

And don't overlook the ones who enter local colleges. They are good prospects for items that go with college life.

Getting married. According to national averages about 25 percent of the teenagers get married shortly after finishing high school. More than 33 percent of the 3 million persons who marry each year are 18 or 19 years old.

These people enter the "we need everything" group quicker than the young people who go on to college. So be alert for them. For some types of business, they may already be good prospects because the owner was able to win their friendship in earlier years.

CASH REGISTERS AND WEDDING BELLS

The bride-to-be begins to need a variety of merchandise almost as soon as her engagement is announced. She needs wedding invitations, a bridal costume, and going-away clothes.

If you have merchandise that she needs, her wedding bells can make your cash register ring. As soon as a young woman announces her engagement you can start a sales campaign with her and her friends. Three suggestions may be helpful.

(1) Send her a card congratulating her. You might want to ask her to bring it in for a gift.

(2) Ask her to select items in your store that she would like for wedding presents.

(3) You may want to telephone or write the mother, listing the items her daughter has selected. If the mother doesn't offer to mention your store, you may want to ask her to do so when she talks with friends, who ask about wedding presents for the daughter.

Finally, a week or so after the wedding get the bride's new address from her mother. You'll want to keep reminding this young woman of your store as she moves into the last stage of the younger customers market — the young homemakers.



YOUNG HOMEMAKERS

Presently new brides and their husbands are entering the young homemakers market at the rate of about 3 million a year. Predictions are that by 1970 there will be around 2 million marriages per year, or 4 million brides and bridegrooms, in this country.

These young adults are on the edge of the "we need everything" market. That is they need many things as they move out to themselves, but they also continue to do a certain amount of pleasure spending.

They have now become self-centered as a couple. They spend money for pleasures they can enjoy together — movies, bowling, ballgames, concerts, and so on.

Depending on what you are selling, these newly married people are potential customers for two kinds of merchandise. First, of course, they need furnishings and other items for their new household. Second, they still want merchandise and services they can enjoy together.

In most cases, they are good customers for both types of goods because both the bride and the bridegroom work. To-

gether they have income to buy, within reason of course, what they want.

Within a few years, these newly married people are further along in the "we need everything" market. Children are beginning to come.

Their interest then changes somewhat. They are still young and will spend for pleasure, but the new baby comes first.

Here the couple's needs continue to increase as the baby grows and as additional children arrive. And the older their children become the deeper these young parents get involved in the "we need everything" section of the younger customers market.

WHAT DOES IT MEAN?

The meaning of the younger customers market varies with the individual small marketer, of course. However, the fact that they are inexperienced buyers can work to the advantage of small marketers.

Remember that these boys and girls from age 15 through 24 are learning to buy. In some cases, they learn about quality and value the hard way as did Joe Cordovan (name disguised). When he was 16, his mother let him purchase a suit by himself.

Joe selected a loud suit of durable material because it was \$15 cheaper than the gray flannel his mother had suggested. He used the savings on his jalopy. A few weeks later he became dissatisfied with the flashy suit, but he was stuck with it.

The store manager got rid of a loud suit, but he lost a young customer. He threw away his chance to bring Joe back into the store.

By helping to guide inexperienced young customers in the making of wise buying decision, small marketers can often encourage these young people to become regular customers. So when you help these consumers — the teenagers, the young marrieds, and the young parents — to get quality and value, you are increasing your chances of building sales to younger customers on a solid basis.

calendar



JUNE 19-21 — MSHP Annual Convention, Carousel Hotel, Ocean City

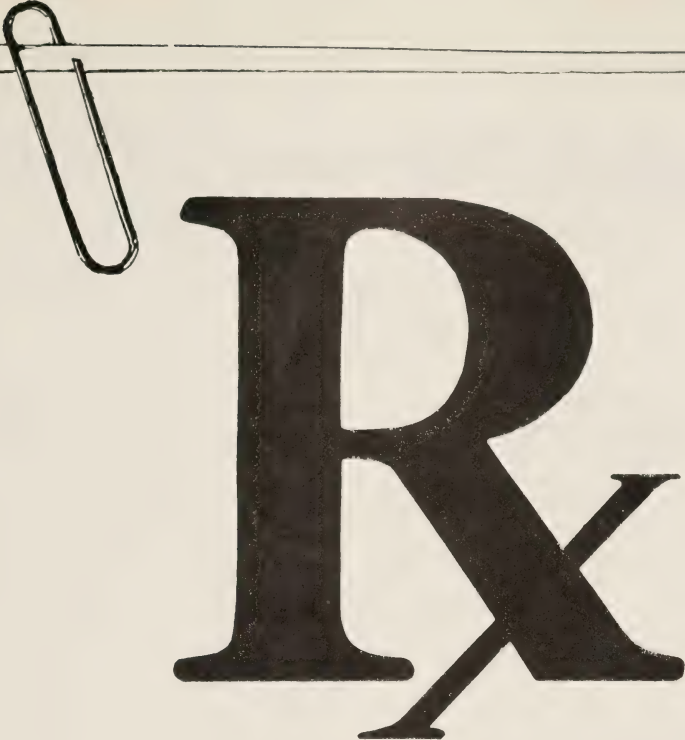
JUNE 21-25 — MPhA CONVENTION — CAROUSEL HOTEL, OCEAN CITY

SEPT. 20 — NARD Convention — San Antonio

OCT. 11 — MPhA DINNER THEATRE — "West Side Story" — Tobey's in Columbia. We have sold out very early the last two years — call reservations to office as soon as you have your group made up.

OCT. 18 — Alumni Association Oyster Roast — Ballasone Memorial Fund, Overlea Hall.

Every Sunday Morning at 6:00 a.m. listen to Charles Spigelmir on WCAO broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore.



Rx

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Shaping Pharmacy's Future

a review of the APhA Annual Meeting

by
Gary Magnus

St. Louis, the Gateway to the West, was the site for the 128th Annual APhA/ 12th Annual SAPHa Convention. The theme for this year's Convention was "Shaping Pharmacy's Future" with both APhA and SAPHa meetings, seminars and general sessions holding discussions and presentations on topics such as the P.D. debate, the APhA Standards of Practice, and increased training in the fields of nutrition and physical diagnosis.

As a graduating senior this was to be my third and last SAPHa Convention, but as an Extern with the MPhA this would be my first exposure to the APhA Convention, (and hopefully not my last).

Eight students from our school had the privilege of attending this Convention: myself, M.T. Andres, Michael Ball-fifth year; Dudley Demarest-fourth year, Cheryl Betz, Connie Recupero, Linda Gray, Jan Stahovec, all from the third year. Also attending from our school were Dr. Shangraw, Dr. Augsburg, Dr. Wiser, Mr. Fedder and Dr. Steiner along with several graduate students; Robert Giannini, Mark Fletcher, Atul M. Mehta, J.E. Botzolakis, S.R. Kalidindi, K. Mitrevej, A. Mitrevej and Aniko Lengyl. All of the professors and graduate students either presented papers or spoke at some of the educational seminars.

Our first two days in St. Louis were spent sightseeing as the Convention did not begin until Friday evening. Highlights of our visits were the Gateway Arch, Anheuser-Busch brewery, the McDonnell Planetarium and laser-light show, Busch Stadium, St. Louis Zoo, Eads Bridge and the St. Louis Visitors Center.

The first official SAPHa function was an icebreaker held Friday night at the Convention Center. Students from over sixty schools were able to intermix and discuss mutual problems and interests. Over a dozen schools gave out name tag stickers as a way of introducing themselves to others. The icebreaker also gave us "oldtimers" a chance to meet again one last time and introduce the newer students to SAPHa policies and procedures. One further purpose of the icebreaker was for the candidates for national office to introduce themselves informally to the other students.

The opening SAPHa general session on Saturday morning began with introductory speeches by the national officers and featured an audiovisual presentation on "Putting the Standards of Practice to work for you." The objectives of

this program and subsequent discussions were to acquaint students with the APhA students of Practice and how they could work for us to maintain a high level of individual professional competence.

With the exception of the general sessions and the House of Delegates sessions, the SAPHa seminars, debates and presentations were usually held concurrently in order to allow students a choice as to which program they wish to attend. For example, on Saturday afternoon there were sessions on institutional pharmacy, community pharmacy, SAPHa special projects and a special session for chapter delegates to train them in proper rules of order and what their responsibilities were.

One of the most important aspects of the SAPHa convention are the resolutions passed by the SAPHa delegates. These resolutions are SAPHa's voice to the APhA and the pharmaceutical profession. At the open resolutions hearing held late Saturday afternoon, time is given for any member of SAPHa or APhA to speak out either individually or as a chapter on the resolutions (proposed by SAPHa members at the eight regional conventions held in the fall and formalized into resolution form by the resolutions committee meeting in January). Discussions on the resolutions are usually enlightening, sometimes spirited, and always controversial. From these discussions, the resolutions committee will meet and recommend adoption, rejection or referral back to committee for each resolution. These recommendations are then voted on at the next House of Delegates session.

In line with the theme of "Shaping Pharmacy's Future", there were many discussions in APhA, SAPHa and the Academies meetings on the future of the profession. On the SAPHa end of the convention, there was a three part debate on the Pharm. D. vs. B.S. issue. The three topics of debate were the manpower issue, the economic issue, and the training controversy. These highly charged debates were held before overflowing crowds of both students and APhA members. The basic issue behind all three debates was not only whether the Pharm. D. will replace the B.S. degree, but will either degree meet contemporary public health care needs. Other issues discussed were the lack of uniformity of Pharm. D. programs, the increased cost of services offered by the more highly trained pharmacists and will the Pharm. D. force the B.S. pharmacists into less satisfactory positions.

The social highlight of the convention was the "Social Extravaganza and Olympic Spectacle" which featured

teams sponsored by SAPHa, APP, APS, and the Board of Trustees in such thrilling events as the pill relay, the talc search, and the suppository shuffle. After a long and exhausting contest, SAPHa and the APS came out in a tie for first. The contest was followed by a dance and an informal trip to Laclede's Landing, a local area with a high density of bars and restaurants.

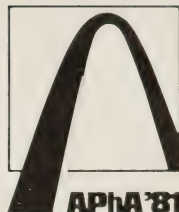
As there was no SAPHa general session on Sunday morning, I had the opportunity to attend the APhA general session. Featured at this session was a debate on the use of the designation P.D. David Clark, Executive Director of the Indiana Pharmaceutical Association, spoke for the designation P.D. (as he did at a recent MPhA debate held in March), while Robert Barnett, Director of Policy Studies-University of Kentucky, spoke against it. Comments and questions from the audience on this subject focused on many aspects, such as, would it be retroactive, public and physician acceptance, changes in education and would it really make a difference? By the end of the discussion it appeared that the major problem was not in the designation (P.D., R. Ph. etc) but in the educational system itself, specifically the two entry level degrees now in effect. A SAPHa discussion of the PD issue during the open resolutions session and results of a questionnaire to SAPHa delegates showed widespread opposition to the use of the designation P.D. The prevailing student attitude (and my own) was that a person should earn a doctorate degree by education not by legislation.

After the APhA/SAPHa brunch, the SAPHa open candidate review was held to allow members to evaluate candidates seeking SAPHa national office. The new format, just adopted this year, did not allow for a nomination speech but instead had each candidate answer two randomly chosen questions, one on organizational affairs and one on professional affairs. This was followed by a short question and answer period with questions from the floor. Following this review each candidate met with the nominations committee in a closed session. After all candidates had been reviewed, the nominations committee slated two candidates for each office and up to six candidates for the three delegate-at-large spots to the APhA house.



The Maryland Student Delegation to the National Pharmaceutical Council Awards Luncheon. Left to right standing: Gary Magnus, Cheryl Betz, Dudley Demarest; seated: M.T. Andres, Connie Recupero, Linda Gray and Jan Stahovec.

American Pharmaceutical Association



In the afternoon I also had the honor of attending the annual meeting of the Pho Chi Society at which Mary Terese Andres, our Chapter President, accepted the award for outstanding chapter for 1980. I would like to take this opportunity to thank Mary Therese, Gary Hollenbeck, our faculty advisor, and the rest of our Chapter for a job well done.

Evenings and other breaks during the convention provided ample time for students, pharmacists and educators to get to know each other on an informal basis. Dinner parties, hotel parties, lunches, breakfasts, cocktail receptions and night on the town all provided opportunities for increased contacts and chances to make new friends. Of course problems do arise when 150 students all decide to eat at the Spaghetti Factory on Saturday night at 7 p.m.

Monday morning saw the opening of the second session of the SAPHa House of Delegates. At this session the report of the Nominations Committee was read and voted on. During this process delegates can vote to adopt the recommendation of the Nominations Committee, reject the recommendation or refer back to Committee. Amendments can also be added or sections deleted during this process. Of the nine resolutions before the house, seven were passed (two with amendments), one on standardization of education was defeated and one on chemically dependent pharmacists was referred back to Committee due to what was felt to be poor wording of the resolution. One problem that led to many discussions and attempted amendments was that, while many students agree with the intent of the resolution, they did not agree to the actual wording. The chemical dependent pharmacist resolution's basic intent was that something should be done for them including recommending that Boards of Pharmacy allow sufficient time for detoxification before deciding on administrative action such as revocation of the license. The resolution itself called for development of both an entire rehabilitative program and educational program to be established by APhA but failed to mention usage of established programs such as A.A. and also did not mention changes by Boards of Pharmacy. The resolution defeated involved support for establishment of minimum standards for Pharm. D. and B.S. degrees in Pharmacy. The defeat was based on students' rejection of the two degree entry level system now in use.

During the past two conventions, the students present have usually tried to attend presentations given by members of our faculty or Association, however Monday morning

posed a very difficult problem. While SAPHa was holding its House of Delegates-Second Session, Dr. Peter Lamy was speaking on "Effects of Aging on Pharmacokinetics", David Banta was speaking on publishing this journal at a Pharmacy Editor's Workshop, and Dr. Wiser, Mr. Fedder and Aniko Lengyl were presenting at a symposium on Blood Pressure Monitoring.

The NPC/SAPHa Awards Luncheon was well attended by most of the over 730 students that were present at this convention. During this luncheon the SAPHa awards were presented to the "Most Active Chapter", the five runner-up, and the best student publication. The University of Minnesota took the top honor with the University of Wisconsin in the first runnerup.

Shortly after lunch, the assassination attempt on President Reagan became known to the hundreds of shocked students and pharmacists. Many students and other conventioners opted to watch television for further information and updates. Those that remained were able to attend sessions on Nutrition Quackery, Health Care Planning, the Pharm. D.-B.S. debate (pt. 3), and a session I attended on SAPHa and State Associations. I am proud to report that our relationship with the Maryland Pharmaceutical Association was envied by many students and state executive directors. Ideas that came out of this session include a Board party in September for handing out licenses, SAPHa membership on Association Board of Trustees and other committees, cooperation on legislation and support for students attending state conventions and other important functions.

The final social event for the SAPHa convention was held in the Sheraton hotel and was entitled the "Spirit of St. Louis" party. Featured was an all-pharmacist band and unfortunately many people felt they should have stuck to drugs instead of music. Attendance was also off due to student exhaustion and the fact that some chapters had to leave early due to exam conflicts. However, it was a time for goodbyes to new friends and old and in many cases, I'll see you next year in Vegas or the fall regionals.

Tuesday morning opened with the final SAPHa House of Delegates session with the major business being the elections and installation of the new SAPHa national officers. I

am proud to announce the election of Dudley Demerast as Speaker of the House for 1981/82. The contests were all hard fought and runoffs were necessary in two of the three elections for officers. During the new business section of this meeting two new resolutions were brought forward for discussion and passage. One of these, submitted by Wayne State, concerned legal drugs being sold as look-a-like controlled substances and the other, submitted by our school, congratulates the U.S.P. for a fine job on the Dispensing Information guide, (similar to a resolution passed by the MPhA last year).

The farewell address by now past-president Cynthia Iannarelli was short and very emotional. Cynthia, who had been Vice-President, President-Elect and then President, conveyed her impressions of those years, the conventions, the major reorganization of SAPHa and APhA and the growing influence of SAPHa on APhA policy.

And so the 12th Annual SAPHa Convention came to a close with the rallying cry of "next year in Las Vegas." Most students left St. Louis shortly thereafter, but about fifty students remained to attend the final APhA House of Delegates session on Wednesday.

The major business of the last APhA House of Delegates session were the reports of the four reference committees. The Educational Affairs Committee recommended adoption of resolutions on training in medical technology, nutrition and physical assessment, all of which passed easily in the house. A resolution on a singular doctoral degree for pharmacy did not do as well and there was much discussion on Pharm. D., P.D. and the American Association of Colleges of Pharmacy. The first policy statement called for no position on the time period required for awarding the professional doctoral degree. This statement passed but the second statement that the APhA not necessarily support the Pharm. D. degree as that degree, failed.

Unlike the previous Committee's report, the Public Affairs Committee policies evoked little discussion. Their proposals were on medical records privacy, removal of hallucinogenic solvents from paints, sprays and glues, third party reimbursement legislation, and prescribing by non-physician health care providers.

The Policy Committee on Scientific Affairs considered and recommended six matters of policy on: Federal regulations of salt in processed foods, use of animals in drug research, carcinogenicity testing, needed drugs of limited commercial value, vaccine liability, and drug product therapeutic equivalence. Again all these resolutions were passed with minimal discussion.

The first three resolutions brought forth by the Professional Affairs Committee were passed intact or amended. Another resolution on drug product sampling was referred back to Committee per their recommendation. However, the last resolution led to the longest and most vocal discussions of the convention. This policy stated that "APhA oppose the designation P.D. as the uniform designation for pharmacy." It appeared from the discussions that students, the Board of Trustees, and hospital pharmacists opposed the designation while community practitioners were fairly split on the subject. Again many speakers mentioned that the fault appears to be with the A.A.C.P. for not encouraging the



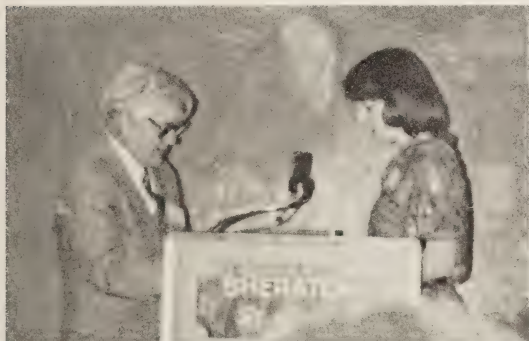
Cheryl Betz (left), the SAPHa Chapter Delegate studies the SAPHa Resolutions at a Region III Caucus.

development of a single entry level degree program. The vote itself, although vocal was 199 to 114 for the resolution which opposed the P.D. designation. As background APhA has endorsed the term "pharmacist" as a uniform designation for pharmacists. The SAPHa delegation, following a general 3-1 student opposition to P.D. voted unanimously against the designation.

Elections were held shortly with D. Stephen Crawford of West Virginia being elected Speaker of the House for 1981/1982 and Stephen W. Schondelmeyer, a former SAPHa president, as vice-Speaker. New Business brought some additional issues to the session. Wisconsin proposed a motion for immediate establishment of a uniform Doctor of Pharmacy degree as the sole entry level degree. California proposed that FDA require prescription drug labels to contain evidence of FDA approval. Texas proposed modification of patent periods and an individual member proposed innovative approaches to the problem of pharmacy crime. All of these new resolutions were passed as written.

The final lunch and General Session concluded the Convention with an excellent speaker on "It's What You Learn After You Know It All."

Conventions mean different things to different students and other participants. Some come for the sight-seeing and tours, others for the parties and get-togethers. Those politically minded come as delegates and/or to run for office. Many come for the exhibits (i.e. free samples) or for the seminars. And others come just as an excuse to get away from school. Myself? I came for the comradeship of students getting together from all across the country, also for the exhibits, delegate sessions and, of course, the parties. But most importantly, I come for the feeling that just maybe what we are doing at these conventions may help improve this world or at least a little part of it.



M.T. Andres receives the Award for best Rho Chi Chapter of the year for the Maryland Chapter.

SAPHa RESOLUTIONS

1. Be it resolved that SAPHa condemns unethical, inaccurate and unprofessional advertising and other misleading methods of recruitment of students into pharmacy school; SAPHa further condemns sexist, racist and other discriminatory forms of recruitment.
2. Be it resolved that SAPHa encourages Schools of Pharmacy to actively seek and obtain input from practitioners and students concerning their curricula.



Dudley Demarest (class of '82) giving his nomination speech for SAPHa Speaker of the House.

3. Be it resolved that SAPHa encourages that a stronger emphasis be placed, within pharmacy school curricula, on providing adequate levels of training and competency in the communication skills necessary for all pharmacy practice settings.
4. Be it resolved that SAPHa encourages State Boards of Pharmacy and the National Association of Boards of Pharmacy to promote the involvement of students in "non-traditional" pharmacy roles by providing internship hours for these experiences. Be it further resolved that SAPHa encourages the National Association of Boards of Pharmacy to establish guidelines, with student input, for States Boards of Pharmacy to follow in accepting internship credits hours for experience gained in "non-traditional" pharmacy roles.
5. Be it resolved that SAPHa discourages the classification of Schedule V drugs as prescription-only products. Be it further resolved that SAPHa supports and encourages the continuing use of professional discretion by pharmacists when Schedule V drug products. Be it further resolved that SAPHa recommends that this matter be referred to the APhA Board of Trustees for possible policy consideration.
6. Be it resolved that SAPHa supports the efforts of any organization and/or governmental body in compiling, evaluating and disseminating accurate statistical manpower data as it effects the quality of patient care and the welfare of the profession of pharmacy. Such data should include, but not be limited to: a) distribution of pharmacists by geography and specialty, b) economics, c) societal need and d) access to health services.

RESOLUTIONS SUBMITTED UNDER NEW BUSINESS

1. Be it resolved that SAPHa condemns unethical, unprofessional and misleading advertisements of non-prescription products by mail-order suppliers. Be it further resolved that SAPHa urges the Federal Food and Drug Administration to investigate these types of advertisements and the companies as to their legality.
2. Be it resolved that SAPHa commends the United States Pharmacopeial Convention for its initiative in developing the outstanding Dispensing Information publication. Be it further resolved that SAPHa recommends the USP-DI serve as a primary source for drug dispensing information in this country.

If our new Order Entry System
doesn't save you time and money
within 60 days, you don't
owe us a dime for the system.



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MARYLAND POISON PREVENTION WEEK

MARCH 15-21, 1981

The following is only a partial list of pharmacies throughout Maryland who participated in Maryland Poison Prevention Week (MPPW). A variety of activities ranging from the distribution of poison prevention literature to exhibits, to merchandise rebates to the sale of Ipecac Syrup at cost were offered in cooperation with the Maryland Poison Center. Thanks to each of these Pharmacies and organizations for making this years MPPW a great success.

Randallstown Professional Pharmacy
Lykos Pharmacy, Timonium
The Medicine Shoppe, Dundalk Avenue
Medical Arts Pharmacy, Frederick — free Ipecac!!
Medical Park Pharmacy, Silver Spring
Valley Professional Pharmacy, Owings Mills — free Ipecac!!
Dolfield Pharmacy, Dolfield Avenue
Park West Medical Center, Park Heights and Belvedere
Safeway Pharmacy, Edgewater
The Village Pharmacist, Gaithersburg
Pharmacy 4200, Edmondson Avenue
Voshells, Wilkens Avenue
Beachys' Pharmacy, Grantsville
Lillichs Pharmacy, Dundalk

Weiners' Pharmacy
Plaza Drug, Edgewood
Calvert Arundel Pharmacy, Owings
The Medicine Shoppe, Frederick
Colonial Apothecary, Pasadena
The Medicine Shoppe, Hagerstown
The Medicine Shoppe, Bel Air
The Medicine Shoppe, Gaithersburg
The Medicine Shoppe, Havre de Grace
The Medicine Shoppe, Wise Avenue
The Medicine Shoppe, Fort Smallwood Road
The Medicine Shoppe, Darlington Drive
The Medicine Shoppe, Baltimore National Pike
The Medicine Shoppe, Leonardtown
Giant Pharmacies — all locations
Drug Fair — all locations
Peoples — all locations
University Hospital Out Patient Pharmacy
Monument Pharmacy
Maryland Pharmaceutical Association
Davis-Calvert Wholesalers
Loewy Drugs
District Wholesalers
Safeway Pharmacies
Phi Delta Chi, Fraternity — School of Pharmacy

Radio! NARD has created radio spot commercials tailored for your store!

- *Grab your community's attention!*
- *Emphasize the many advantages of independent pharmacies!*
- *Tie your pharmacy into a national ad program stressing the theme, Ask Your Family PharmacistSM**

Yes, I want to use radio and participate in NARD's new advertising campaign! Please forward _____ sets of *Ask Your Family PharmacistSM radio spot commercials at \$ _____* (check enclosed).

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_____ [NARD Member Number]

_____ [Street Address]

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DO YOU KNOW HOW TO USE RADIO?

**IT'S AMERICA'S
MOST COST-EFFECTIVE,
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All spots professionally produced . . . musical backgrounds make them totally memorable to potential customers. Spots emphasize that you—their community pharmacist—are concerned . . . involved in your community's welfare! That you are eager to respond to health-

care questions . . . health problems . . . and give sound advice on OTC medications.

Commercials are available in two versions: one runs 30 seconds; the other 60 seconds . . . both with room at the end for personalization with your store's name, address and special services. They are available on reel-to-reel tape . . . ready for immediate use by your local radio station.

Designed and available exclusively for NARD members, these spot commercials are available for \$25 for both lengths . . . far less than what it would cost you to create them yourself!

To order, complete the form below and return it with your check to: The National Association of Retail Druggists, 1750 K Street, NW, Washington, DC 20006.

**Ask Your Family Pharmacist is a service mark of the National Association of Retail Druggists.*



The SAPHa Chapter held another successful coffee house in the Kelly Memorial Building on March 20th.



Gary Magnus and Linda Gray express differing opinions over the professional designation issue. Linda is holding a button that says "P.D. Now."



The SAPHa Chapter uses the basement of the Kelly Building for the fundraiser which is attracting students from outside of pharmacy School.



Entertainment is supplied by pharmacy students who often show they have hidden talents.

This page donated by
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Pictures courtesy Abe Bloom — District Photo

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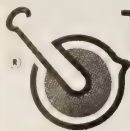


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inventory less. That's one way you can save money and have the products your customers want when they need them. Our management services give you "up-to-the-minute" techniques on inventory control, cash flow, pricing and other methods of managing your business for greater profits.

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Baltimore Division
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Johnstown Division
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for pharmacists**



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with a full program
of services
is our
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- **A Special Lecture Program.** Continuing education conducted by experts in several fields to give you a sound basis for making informed decisions.
- **Pharmacists' Advisory Panel.** A liaison group that meets annually to keep us fully informed about your changing needs.
- **A Postgraduate Education Funding Program.** Financial support to national, state, and local association meetings to help members stay current with the latest professional developments.
- **Internship/Clerkship Programs.** Educational enrichment programs at MSD designed to help pharmacy students make a more secure transition from student to professional.
- **A Quarterly Publication for Pharmacists, edited by Mickey Smith, Ph.D., University of Mississippi.** A journal featuring concise, objective analyses of current issues bearing on the pharmacy profession.

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NARD is pleased to announce the third printing of the popular NARD publication "Handbook for Pharmaceutical Services in Long-Term Care Facilities."

This practical publication translates federal regulations into practical language and provides sound advice on pharmaceutical applications in the nursing home arena.

Through the generous support of the Smith Kline & French Company we have been able to provide over 25,000 copies of this publication to practitioners and students interested in nursing home practice. We have a limited number of copies available for use at your upcoming meetings and seminars.

Please send your requests to:

NARD
1750 K Street, N.W.
Suite 1200
Washington, D.C. 20006
Attention: Jack Tighe

Mr. Charles Spalding
PRB Executive Secretary
1D5 East Low Rise
6401 Security Blvd.
Baltimore MD 21235

Dear Sir:

I would like to offer the following comments on the proposal to lower 14 MAC prices for the Medicaid Program. There can not be any argument against the government wanting to pay no more than a fair price for medication but there are examples in all areas that the lowest price is not necessarily the best price. You would not want the lowest bidder of a construction job to be one who might build a building that collapses. A fair price must be paid to have a job done right. When MACs were set on these particular drugs for the first time PRB was saying to the pharmacist that you know we can buy at these prices and you will not pay more. Of course, HEW pointedly avoided the fact that pharmacy fees are inadequate and the 'fat' was what kept pharmacies in the program.

Despite that, we managed to survive by investing our money in larger quantities — 1000s, 10,000s even more. HEW does not provide interest free money for us to make these volume purchases. Now you are saying — good for you for using money you could have invested elsewhere — now give us that advantage also.

Unless the intent of HEW is to drive out of business those pharmacies which must derive a profit from the prescription department you will find tactics such as this will have a negative payoff — in health care and employment opportunities. Perhaps the idea is to put pharmacists at the other end of the spectrum — what purpose would that serve?

And the effect on the manufacturers and the total price of drugs? Check the prices you pay for non-competitive drugs. They simply shift the price to those items. Keflex just went up \$5.00 per hundred — more of an increase than the total price you are willing to pay for 100 Ampicillin which serves most of the same purposes as Keflex — congratulations — if Lilly can't make it on inexpensive drugs — you pay for the sky high one. That's economy?

Sincerely yours,

Melvin N. Rubin

Dear Pharmaceutical Associate Executive:

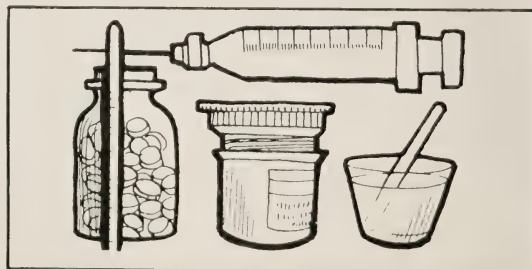
The subject of reviewing and encouraging appropriate antibiotic usage in hospitals continues to stimulate keen interest. Because of the vital importance of this subject, we are convening a Third National Conference, ANTIBIOTIC REVIEW — 1981: Strategies for an Effective Program," to be held in Washington, D.C. August 10-11, 1981.

In view of the pharmacist interest in quality of patient care and cost containment, and the important role pharmacists can play in antibiotic review, we think your members will be interested in learning of this Conference. We would appreciate it very much if you would announce it in any publications you sent to your members. A suggested wording would be as follows:

"ANTIBIOTIC REVIEW-1981:
Strategies for an Effective Program"
Sheraton Washington Hotel, Washington, D.C.
August 10-11, 1981
Contact: Sandy McMillan
Suite 221-K, 67 Peachtree Park Drive,
Atlanta, GA 30309

Sincerely,

Leslie C. Norins, MD, PhD
Executive Director





Donald R. Baugher, a consulting Pharmacist from Beardstown, Illinois was one of the featured speakers at the Continuing Education Coordinating Council's program on Primary Care held March 19, 1981 at the Kelly Memorial Building.



Robert E. Davis, a clinical pharmacist from Lexington South Carolina shared his experiences with the audience. His article appeared in the May 1981 issue of the Journal.



Harry B. Finke Jr., Owner of a Medicine Shoppe in Baltimore, served as moderator for the program.

Pictures Courtesy of Abe Bloom
District Photo

JUNE 1981

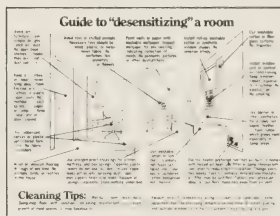
"Tween Scripts

By Jake Miller, Pharmacist
Manager, Professional Relations
A. H. Robins Company, Inc.



Health Care and "do-it-yourself"

A friend of mine in the publishing business tells me that the 80's are going to be the "do-it-yourself" decade. Books on this subject are selling in record numbers. A similar trend has occurred in health care. For example, the FDA's OTC panels have recommended that 29 prescription drugs be reclassified and made available for self-medication. Our popular antihistamine, Dimetane®, was one of those prescription products reclassified and about 2 years ago we repackaged the tablets and elixir for the OTC market. But we didn't stop there. If you open one of our Dimetane packages, inside you'll find a little leaflet giving suggestions on how to "desensitize" a room for the allergic person. This



leaflet is identical to the ones we make available for Allergists and other physicians to give to their patients. In simple terms, it tells some of the things that should

be done to reduce the "allergic load" within the house.

No doubt an occasion may arise from time to time when such information may prove useful to you in counseling a patient with an allergic problem. This is one reason why we include such service material in our OTC Dimetane packages. . . so that the customer's purchase includes both an effective product and good home medical advice.

Incidentally, we have additional allergy patient aids available which may be of service to your patients. Ask your local A. H. Robins representative on his next visit for a supply.

Jake Miller

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He knows the practice of pharmacy inside and out.

In fact, during the years since he graduated from pharmacy school in 1964, he has done everything but teach it.

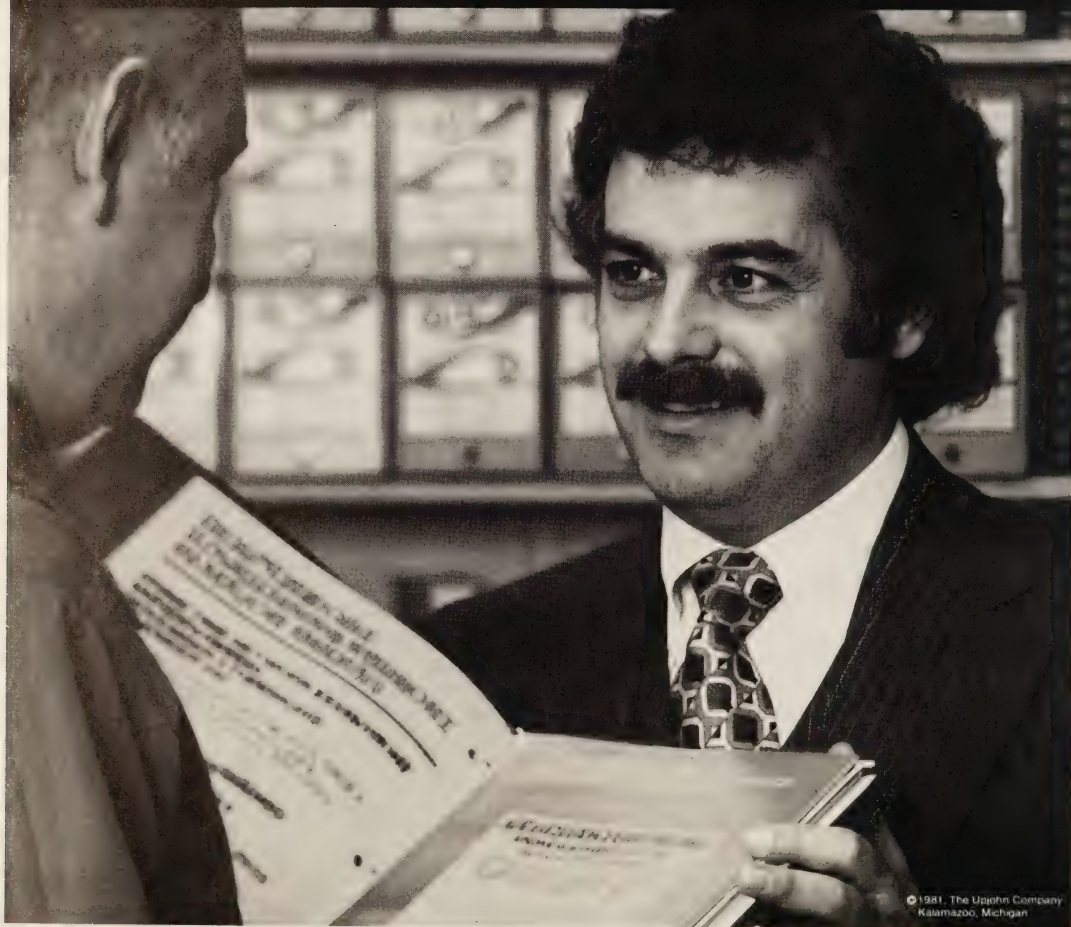
Before joining Upjohn in 1973 as a sales representative, Vince worked as a pharmacist in a community drug store; in a small chain drug store; in a large chain drug store; and as assistant director of pharmacy at a large hospital.

This experience has given Vince a strong personal insight into the needs of other pharmacists. His background, training and continuing education all help Vince provide information and service to pharmacists in his area.

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- ☐ TO SAVE TIME YOU SHOULD PRESENT YOUR CARD WITH THE PRESCRIPTION OR IDENTIFY THE CARD WHEN PHONING THE PHARMACY.
- ☐ MOST PROGRAMS HAVE SOME OF THE FOLLOWING RESTRICTIONS:
- ☐ ALLOW DEPENDENTS TO USE YOUR CARD ONLY TO A CERTAIN AGE
- ☐ LIMIT YOU TO A MONTH'S SUPPLY OF MOST DRUGS ON EACH FILLING. (SOME ALLOW LONGER THAN A MONTH OF A FEW SELECT MEDICINES.) USUALLY YOU CAN GET ADDITIONAL REFILLS WHEN ORIGINAL QUANTITIES HAVE TO BE REDUCED.
- ☐ A FEW PROGRAMS LIMIT THE DOLLAR AMOUNT OF MEDICINE PER PRESCRIPTION.
- ☐ MOST PROGRAMS WILL NOT PAY FOR AN ITEM THAT YOU CAN BUY WITHOUT A PRESCRIPTION (EXCEPT INSULIN).
- ☐ STATE ASSISTANCE PROGRAMS HAVE MANY OTHER RESTRICTIONS.
- ☐ ONLY A FEW PROGRAMS PAY FOR BIRTH CONTROL PILLS.

**WE WILL HELP YOU AS MUCH AS POSSIBLE
WITHIN THE LIMITATIONS OF YOUR PROGRAM.**

MEMBER MARYLAND PHARMACEUTICAL ASSOCIATION

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The original, effective decongestant is also the original profit generator.

- #2 "cold" tablet in pharmacies for the 24-tablet size packages¹
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- More than 383,000,000 tablets sold last year... and growing at a rate faster than the market*

Then came

SUDAFED PLUS

The potent decongestant/antihistamine allergy/cold product for year-round relief of nasal and sinus congestion, watery, itchy eyes, and sneezing.

- 300% ahead of sales forecast since its introduction
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SUDAFED COUGH SYRUP

For temporary relief of cough, stuffy nose, and sinus congestion symptoms due to colds and flu. The new potent combination of dextromethorphan to relieve coughs and guaifenesin to loosen congestion is added to the original Sudafed formula.

- Inherits the great "Sudafed" name — a name you and physicians recommend... and customers use and keep coming back for more!



GET YOUR SHARE —
DISPLAY THE WINNERS... AND CASH IN ON THE
PROFIT-MAKING POWER OF THE ENTIRE

SUDAFED FAMILY OF COUGH/COLD/ALLERGY RELIEF

The Sudafed name and quality...
breeding customer loyalty and profits for you

Reference: 1. Independent Market Research Audit, 12 months ending March 1991, based on drugstore sales of OTC products. *Source: Burroughs Wellcome Co.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Nurse Practitioner Regulations

The following regulations were recently jointly promulgated by the Medical and Nursing Boards to address the practice of Nurse Practitioners "prescribing Drugs" is listed as one of the functions allowed under these regulations. This appears to be in conflict with existing pharmacy law which specifically lists the "authorized prescribers" and does not include Nurse Practitioners. The Association is attempting to clarify this area and will provide information to members on this matter in future issues.

.01 Definitions.

A. The following terms have the meanings indicated.

B. Terms Defined.

- (1) "Joint Committee" means the Joint Committee on Nurse Practitioners, composed of equal number of members appointed by the Medical and Nursing Boards.
- (2) "Medical Board" means the Board of Medical Examiners.
- (3) "Nursing Board" means the Board of Examiners of Nurses.
- (4) "Nurse practitioner" means a registered nurse who by reason of certification under these regulations may engage in the activities authorized by these regulations.
- (5) "Physician" means an individual licensed to practice medicine in this State.
- (6) "Written agreement" means the development and implementation of a written agreement between a nurse practitioner and a licensed physician concerning the performance by the nurse practitioner of the functions authorized by these regulations.

.02 Nurse Practitioner — Standards of Practice.

A. A nurse practitioner may perform the following functions under the terms and conditions set forth in the written agreement:

- (1) Comprehensive physical assessment of patients;
- (2) Establishing medical diagnosis for common short-term or chronic stable health problems;
- (3) Ordering, performing, and interpreting laboratory tests;
- (4) Prescribing drugs;
- (5) Performing therapeutic or corrective measures;
- (6) Referring patients to appropriate licensed physicians or other health care providers;
- (7) Providing emergency care.

B. Before a nurse practitioner may practice he shall:

- (1) Obtain certification under these regulations;
- (2) Enter into a written agreement with a physician whereby the physician on a regularly-scheduled basis shall:
 - (a) Accept referrals,
 - (b) Establish and review drug and other medical guidelines with the nurse practitioner,
 - (c) Participate with the nurse practitioner in periodically reviewing and discussing medical diagnoses and the therapeutic or corrective measures employed in the practice setting,
 - (d) Jointly sign records if needed to document accountability of both the physician and nurse practitioner,
 - (e) Be available for consultation in person, by telephone, or by some other form of telecommunication, and
 - (f) Designate an alternate physician if the physician identified in the written agreement temporarily becomes unavailable;

(3) Obtain approval of the written agreement as set forth in Regulation .06.

C. A nurse practitioner may practice only in the area of specialization in which he is certified.

D. A nurse practitioner shall immediately advise the Nursing Board if a written agreement is ended by either party.

E. A nurse practitioner shall submit a new or amended written agreement for approval before:

- (1) Altering the practice setting; or
- (2) Modifying or expanding the medical functions that

.03 Certification.

A. An applicant for certification as a nurse practitioner shall:

- (1) Hold a current license to practice registered nursing in the State;
- (2) Complete in full the application for certification as a nurse practitioner;
- (3) Pay all fees established by the Nursing Board;
- (4) Complete a program for preparation of nurse practitioners approved by the Nursing Board; and
- (5) Pass an examination as designated by the Nursing Board.

B. The Nursing Board shall:

- (1) Maintain an up-to-date list of all nurse practitioners certified in the State; and
- (2) Include on the nurse practitioner's registered nursing license an indication that the licensee is certified as a nurse practitioner and a designation of the nurse practitioner's area of specialization.

.04 Renewal of Certification.

A. A certification as a nurse practitioner expires at the same time as the nurse practitioner's registered nursing license unless the certification is renewed for a 2-year term as provided in this regulation.

B. Before his certification expires, a nurse practitioner may renew for an additional 2-year term, if the nurse practitioner:

- (1) Is otherwise entitled to be certified;
- (2) Pays to the Nursing Board all appropriate renewal fees set by the Nursing Board; and
- (3) Submits to the Nursing Board:
 - (a) A renewal application on the form that it requires, and
 - (b) Satisfactory evidence that any certification received is current if that certificate was the basis for the certification issued under these regulations.

.05 Current Practitioners.

Registered nurses who are currently performing the functions set forth in Regulation .02 may continue to do so without Maryland certification for a period not longer than 1 year after the date of adoption of these regulations.

.06 Joint Committee on Nurse Practitioners.

The Nursing and Medical Boards shall establish a joint committee to do the following:

A. Develop a written framework to be used in writing written agreements; and

B. Make recommendations to the Nursing Board regarding approval of written agreements submitted for review, except that no written agreement may be approved by the Nursing Board unless the Medical Board reviews and approves the physician's role as described in the written agreement.

C. The joint committee shall be composed of an equal number of members appointed by the Nursing and Medical Boards.

D. Members of the joint committee may be members of the Nursing or Medical Boards or may be designees of each appointing Board.

.07 Unlawful Practices:

A. Unless authorized to practice under these regulations, an individual may not use the words "nurse practitioner" or any other words, letters, or symbols with the in-

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

BENZODIAZEPINE DEPRIVATIVES:

Using drugs in single daily doses will help improve patient compliance and thus reduce the incidence of therapeutic failure. Side effects may be minimized if the daily dose is taken just prior to retiring. Two benzodiazepine derivatives, including clorazepate (Tranxene), were administered in single daily doses and the regimens were found to be both safe and effective for the relief of anxiety without producing daytime drowsiness or other serious or unexpected side effects. Some physicians still prefer multidose regimens in situations where patients may benefit psychologically from the act of taking medication at certain intervals during the day. *CLIN THER*, Vol. 3, #3, p. 209, 1981.

ACETAMINOPHEN:

Although both aspirin and acetaminophen were synthesized before the turn of the century, acetaminophen came into general use only in the 1950's. Today it has gained wide popularity to the point where it has replaced aspirin as the drug of choice in many types of mild pain. Aspirin and acetaminophen have comparable analgesic and antipyretic activity, but acetaminophen does not alter platelet function, prolong pregnancy or parturition, or irritate the gastrointestinal epithelial lining. Aspirin does have important anti-inflammatory effects and is clearly superior to acetaminophen in treating inflammatory conditions. *J AM MED A*, Vol. 245, #3, p. 283, 1981.

TRIPHASIC ORAL CONTRACEPTIVES:

A new combination of estrogen and progesterone has been employed to help increase the reliability of oral contraceptive preparations. The combination is similar to that used in the older sequential contraceptive products, but differs in that the new agent uses progesterone during the entire 21 days of therapy. The difference between the products is that the dose of progesterone increases through the cycle. Low doses of progesterone are used during the first 6 days and are increased during the next 5 days. The final 10 days of therapy utilize tablets which contain the highest amount of progesterone. The amount of estrogen used remains constant during the 21 days of therapy. The products, marketed in Europe by Wyeth and Schering, are more expensive than oral contraceptives currently on the market. They are not yet available in this country. *DRUG THER B*, Vol. 18, #25, p. 28, 1981.

PERSISTENT NON-GONOCOCCAL URETHRITIS:

It has been estimated that approximately 40% of the non-gonococcal urethritis is caused by an organism known as *Ureplasma urealyticum*. General, tetracycline derivatives have been effective in eradicating this organism, but recent reports indicate that resistant organisms are appearing. Infections which persist even in the presence of tetracycline therapy should probably be treated with erythromycin. *ANN INT MED*, Vol. 94, #2, p. 192, 1981.

ANTIDEPRESSANTS:

Two new antidepressants are expected to appear on the United States market within 18 months. Trazodone (Desyre) is being tested by Mead-Johnson while Organon is conducting research with mianserin (Bolvidon). The drugs are thought to produce fewer cardiovascular effects than present tricyclic antidepressants. *FDC RPT*, Vol. 43, #5, p. 8, 1981.

TIC DOULOUREUX:

Trigeminal neuralgia or tic douloureux is a condition which is seen in elderly patients. It manifests itself as severe facial pain which generally affects only a single side. Most often the pain is associated with the mandibular and maxillary divisions of the fifth cranial nerve. The attacks last less than one minute and seem to affect the right side of the face more than the left. Females are most often afflicted. Drug therapy involves the use of carbamazepine (Tegretol), although other agents including phenytoin (Dilantin), chlorphenesin (Maolate) and clonazepam (Clonopin) have been shown to have some value. *AM FAM PHYS*, Vol. 23, #2, p. 153, 1981.

PSORIASIS:

Literally thousands of therapeutic regimens have been designed in efforts to afford relief to patients with psoriasis. A recent study utilizing a regimen which consisted of betamethasone dipropionate glycol ointment in 0.05% concentrations resulted in complete clearing of the lesions in two weeks in 21% of those in the experiment. Sixty-eight percent of those in the study reported complete disappearance of scaling, the major cosmetic complication of this disease. *CLIN THER*, Vol. 3, #3, p. 156, 1981.

NALBUPHINE:

Nalbuphine is generally given by injection, but experiments conducted in patients with postoperative pain showed it to be effective orally. The analgesic was used in doses of 60 mg for oral administration, but may work well at even lower doses. *CLIN PHARM*, Vol. 29, #2, p. 174, 1981.

CEFOTAXIME:

A new cephalosporin derivative is scheduled to be released shortly. The drug, cefotaxime (Claforan), is the first of a new group of agents known as third generation cephalosporin derivatives and is said to have activity against some strains of *Enterobacter*, *Proteus vulgaris*, and *Pseudomonas aeruginosa*. Other agents in the same chemical class include I-oxacephalosporin (Eli Lilly and Company) and cefoperazone (Pfizer). *FDA RPT*, Vol. 43, #2, p. 3, 1981.

BACAMPICILIN:

A new oral semi-synthetic penicillin derivative has been marketed as bacampicillin (Spectrobid). The antibiotic breaks down to form ampicillin as it is absorbed from the gastrointestinal tract and thus should be used only as a sub-

stitute for ampicillin. Bacampicillin differs from ampicillin in that it requires only twice daily administration in order to keep plasma levels within the therapeutic range. *DRUG THER*, Vol. 11, #2, p. 39, 1981.

TETRACYCLINE:

Tetracycline has been shown to increase intracranial pressures in infants and evidence now indicates that the same thing happens in adolescent girls. While being treated for acne, five women developed signs of intracranial hypertension, namely headaches. The incidence of the headache may be more severe if vitamin A supplements are also being used. The condition reversed itself when the tetracycline was withdrawn, but physicians are cautioned to associate headaches with tetracycline administration and alter therapy if necessary. *BR MED J*, Vol. 282, #6257, p. 19, 1981.

NON-GONOCOCCAL URETHRITIS:

Chlamydia trachomatis is a sexually transmitted pathogen which is often the cause of non-gonococcal urethritis (NGU). The disease is now thought to be twice as common as gonorrhea in men. Tetracycline and erythromycin have been found to be effective treatment for the infections, but complete eradication necessitates treatment of sexual partners. *JAM MED A*, Vol. 245, #4, p. 381, 1981.

ORAL CONTRACEPTIVES:

Antipyrine has long been used as a drug which is of value in determining the activity of the cytochrome P-450 dependent liver microsomal enzyme system. Patients receiving low dose oral contraceptive steroids were given antipyrine and the metabolism of the test drug was monitored. It was noted that the clearance of antipyrine decreased in the presence of the steroids and thus the authors have concluded that even low-dose estrogen-containing oral contraceptive steroid preparations may reduce the metabolism of other pharmacological agents. *CLIN PHARM*, Vol. 29, #1, p. 106, 1981.

TOPICAL STEROIDS:

The use of topical steroidal preparations is widespread and often is looked upon as a rather benign type of therapy. Side-effects can occur when these agents are applied to the skin. The fluorinated preparations may produce symptoms similar to acne, striae, premature aging of the skin, hypertrichosis, perioral dermatitis, glaucoma and even adrenal suppression. Generally a non-fluorinated preparation is preferred to those containing fluoride because the former have fewer side effects and are less expensive. The fluorinated derivatives seem to be most beneficial when used to treat patients with severe acute dermatoses. *AM FAM PHYS*, Vol. 23, #2, p. 171, 1981.

APRINDINE:

An experimental antiarrhythmic agent, aprindine, is a tertiary amine which has some local anesthetic activity. It has a long half-life and is metabolized by the liver. Aprindine is absorbed when given orally or can be injected intravenously. Today it is being used primarily to treat arrhythmias unresponsive to conventional therapy. Side effects considered dangerous were seen in only two percent of the patients included in this study. *HOSP FORM*, Vol. 15, #10, p. 775, 1981.

TAMOXIFEN:

Tamoxifen (Nolvadex) has been used in post-menopausal women with breast cancer. It was effective as measured by tumor regression and demonstrated only a low incidence of side effects. *N ENG J MED*, Vol. 304, #1, p. 16, 1981.

VAN GOGH:

Vincent Van Gogh died in 1890 after having a life full of medical and psychological problems. Many of the paintings he produced in his later years were characteristically heavy with the use of the color yellow. Many of these also contained numerous halos. It has been suggested that he had been treated for epilepsy with digitalis, a drug used to treat that condition prior to the turn of the century. His fascination for yellow may have been a manifestation of xanthopsia and coronas, side effects of digitalis. Twice he painted portraits of his personal physician and in both paintings, the physician was holding a foxglove plant, the source of digitalis. *JAM MED A*, Vol. 245, #7, p. 727, 1981.

THEOPHYLLINE-ALLOPURINOL INTERACTION:

Patients receiving concomitant theophylline and allopurinol (Zylorprim) therapy were examined to see if the xanthine oxidase inhibitor might have an effect on the metabolism of the xanthine derivative. It was noted that short-term administration of allopurinol did not significantly alter the metabolism of the antiasthmatic drug, but significant changes were observed after the drug had been used for 14 days. Since theophylline metabolism is reduced when allopurinol is present, dosage adjustments should be utilized in order to prevent toxicity. The authors also suggest that drugs be administered for time periods longer than just a few days before they are determined not to affect one another. *CLIN PHARM*, Vol. 29, #2, p. 224, 1981.

PRESCRIPTION DRUGS FOR 1980:

The list of most prescribed drugs for the year 1980 showed Smith, Kline and French Company with two products within the top five products prescribed. Tagamet led the list while Inderal, Valium, Motrin and Dyazide made up the remainder. They were followed in order by Clinoril, Keflex, Aldomet, Lasix and Naprosyn. Ortho-Novum was the most prescribed oral contraceptive preparation. *FDC RPT*, Vol. 43, #5, p. 6, 1981.

VERAPAMIL:

Introduced in Germany in 1962, verapamil may be the first of a new class of pharmacological agents known as calcium channel blockers to be introduced to the United States market. The drug has been shown to be effective in controlling paroxysmal supraventricular tachycardia and atrial fibrillation or flutter. The drug seems to block the influx of calcium ions in the SA and AV nodes resulting in the reduction in the speed of the depolarizing phase of the action potential. The drug is especially valuable in patients who have respiratory complications because verapamil will not interfere with bronchiolar relaxation as may occur when beta-adrenergic blocking agents are utilized. The drug is incompletely absorbed when given orally and thus will be available initially only as an injectable preparation. *ANN INT MED*, Vol. 94, #1, p. 1, 1981.

Perspectives in Pharmacy

Capitation*— Reimbursement for Pharmacy Services

Presented
in the interest of
better-informed
pharmacy.

*Capitation is a system of payment by which a provider receives a fixed amount for services rendered each person for a given time period, usually a month.

Jean Paul Gagnon, R.Ph., Ph.D.
Professor, Pharmacy Administration
School of Pharmacy
University of North Carolina at Chapel Hill

"Capitation is not new to pharmacy. As early as 1969, this system of payment was being discussed as a reimbursement method for pharmacy services.

"There are theoretical advantages to pharmacists being paid a fixed monthly rate per patient:

- service and administrative costs could be lowered;
- pharmacists would be able to consider patient needs first;
- pharmacists could keep abreast of current drug therapies and technology;
- greater continuity of patient care could be provided;
- utilization of high-cost services could be lowered;
- more extensive preventive health efforts could be made;
- and more favorable health outcomes might result.

"On the other hand, capitation may stimulate providers to:

- devote fewer hours to patient care;
- refer patients to other facilities more readily;
- be more inflexible and less responsive in dealing with patients;
- screen potential enrollees for health status;
- place profit before services;
- and delay or prolong services.

"There is little documentation to support either the advantages or the disadvantages of capitation to the pharmacy profession. Because its use so far has been limited, capitation needs additional evaluation before a decision concerning its utilization can be made.

"In the long run, after pharmacists have realized 'windfall profits' through implementation of such cost-saving strategies as generic substitution and use of OTC drugs, capitation may be attended by the same problems as the fixed-fee

method. It is likely that, in times of tight money, legislators and program administrators would exhibit the same attitudes about capitation as they currently do toward fixed professional fees—they will be tempted to minimize costs by not raising the capitation rate. In fact, because of 'windfall profits' that will be generated in the early years of the capitation approach, state legislators will probably tend to reduce the rate. At the very least, pharmacists will be asked by legislators to justify rate increases by conducting cost studies of their operations.

"There is as much controversy today about third-party reimbursement for pharmacy services as there was in 1968. Because of federal antitrust laws and the lack of consensus on the part of pharmacists, pharmacy organizations have been unable to convince program administrators of the value of their services and the advantages of competitively determined prices as opposed to a cost-plus approach. In the final analysis, the capitation approach may serve only to delay solution of the reimbursement problem."

Raymond A. Gosselin, R.Ph., Sc.D.
President, Massachusetts College of Pharmacy
and Allied Health Sciences

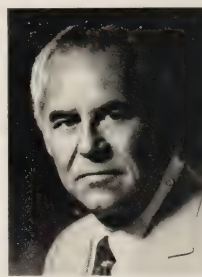
"Subjective appraisals of the capitation system are apt to be inconclusive in the short term, because, initially, there would seem to be some advantages, e.g., money up front, no claim forms, etc. But, at some point, pharmacists will have exhausted all opportunities to hold down costs by substituting less expensive drugs, eliminating refills, curtailing overuse, and switching patients to home remedies. Meanwhile, increasing amounts for rent, light, heat, taxes, and the like will have to be paid.

"Program administrators, faced with the need to eliminate the 'fat' from budgets and aware that pharmacists retain any amount left from the initial capitation fee that is not spent on program recipients, would inevitably cut successive annual funding.

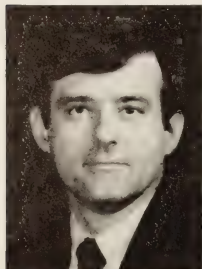
"The bottom line of any proposed capitation system would not be in savings realized by curtailing overuse or by switching patients from prescription drugs to over-the-counter ones but in using less expensive generic drugs. The capitation system, in effect, would be no more than a mechanism for forcing the use of the cheapest drugs available. Making a choice based on price as the sole criterion does not involve professional judgment. Under a capitation system, pharmacists would have to resort to the lowest-priced drugs in order to remain in business.

"As long as pharmacy remains a predominantly private enterprise in this country, and there is little to indicate otherwise, incentives for providing new and better services—including patient consultation and monitoring—need to be positive rather than negative. New activities for pharmacists must be justified in terms of building clientele, increasing volume and business, and earning a reasonable profit.

"Pharmacists can play a major cost-saving role in health care by helping people get well and stay well by means of the proper application of efficacious drug therapy. Billions can be saved in physicians' fees, hospitalization costs, diagnostic tests, and the like by aggressive and positive application of pharmacists' skills. Such expertise is valuable, and pharmacists should be paid for their contribution. The cost of such services is indeed small in relation to the genuine savings in total health care that can be realized."



Raymond A. Gosselin, R.Ph., Sc.D.



Jean Paul Gagnon, R.Ph., Ph.D.



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- Notification for the patient under the Drug Product Selection Law
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- The Association's Employment Clearinghouse, helping pharmacists and employers find one another
- I.C. collection help
- Information on the NEW USP/NF on sale from MPhA.

For these and many other services, contact Sharon at the MPhA Office. (301) 727-0746

The University of Maryland School of Pharmacy is interested in including 4 antique pharmacy fixtures in its new building, planned for completion in 1983. Anyone interested in such an idea is invited to call the Dean's Office, 528-7650.

Pharmacy space in a medical building coming in late 1981 on Reisterstown Road in Owings Mills (across 1500 units apartment complexes). Suites will be condominiumized for sale or lease. Call evenings 744-0675.

The **Elder Ed** program has developed the following brochures for older consumers: "Sublingual Nitroglycerin Tablets, some do's and don'ts", "Vitamins are not Enough!", "How to Select Your Pharmacy", and "You and Your Medicines". For additional information contact Elder Ed at (301) 528-3243.

A free brochure listing all tapes for the TELMED program is available. Call 528-6294 or write the office of the Director, University of Maryland Hospital, 22 South Greene St., Baltimore, 21201.

Notice of New Regulation

Regulation 10.34.08 — Prescription Initialing and Dating

.01 Original and Refill Prescriptions

Every prescription shall be recorded with the following information:

- A. Date of filling or refilling;
- B. Pharmacist responsible for filling or refilling the prescription.

.02 Method of Record

- A. In pharmacies with computers, the required information shall be readily available from stored information, contained in the computer records.
- B. In pharmacies without computers, the information required shall be indicated by the pharmacist initialing the original or refill prescription.

Effective date: February 6, 1981

TEL-MED PROGRAMS IN OPERATION THROUGHOUT MARYLAND

Prince George's County	345-4080
Cheverly	
Sacred Heart Hospital	777-8383
Cumberland	
Provident Hospital	728-2900
Baltimore	
University of Maryland Hospital	528-3111
Baltimore	
Memorial Hospital	822-9198
Easton	

Alumni of the Philadelphia College of Pharmacy and Friends will have a breakfast at the M.Ph.A.-Delaware joint Convention in Ocean City on Tuesday, June 23, 1981 at 8:30 a.m.

Hotline for impaired Physicians (301) 467-4224

Hotline for impaired Dentists (301) 796-8441

Recent graduate wanted to work at established community pharmacy with outlook toward future ownership. Contact Box 10.

Graduating pharmacy student desires full-time position in independent pharmacy — mature, responsible. Resume and references on request. Box 7 MPhA Office, 650 W. Lombard St., 21201.

Part time help wanted in active community store in Baltimore. Flexible schedule. Contact Box 15, MPhA office, 650 W. Lombard St., Baltimore 21201.

The Guy in the Glass

*When you get what you want in your struggle for self
And the world makes you "King" for a day,
Then go to the mirror and look at yourself
And see what that guy has to say.*

*For it isn't your father, or mother, or wife
Whose judgment upon you must pass;
The fellow whose verdict counts most in your life
Is the guy staring back from the glass.*

*He's the fellow to please — never mind all the rest,
For he's with you clear to the end.
And you've passed your most dangerous, difficult task
If the guy in the glass is your friend.*

*You may be like Jack Horner and "Chisel" a plum
And think you're a wonderful guy,
But the man in the glass says you're only a bum
If you can't look him straight in the eye.*

*You can fool the whole world down the pathway of years
And get pats on the back as you pass,
But your final reward will be heartaches and tears
If you've cheated the guy in the glass.*

— Dale Wimbrow

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THE MARYLAND PHARMACIST

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Women in Pharmacy

— Jackie Collins



Doc Sterling — the end of an era

— Lila Line

Maryland Labor Organizations

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THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
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Throughout the next 12 months, as we address the issues and implement the programs of the MPhA, I will repeatedly stress one concept — that is COMMUNICATIONS. There are many different levels and channels on and through which communications can occur in our profession. Some of those channels on various levels are effectively open. Others need improvement.

The celebration of our Centennial will give us an excellent opportunity to communicate our messages not only within our profession, but to our patients, other health practitioners and the government.

We encourage all expressions of opinion. We ask that in the case of criticism, it be communicated not only among the general membership, but especially to those officers who are responsible. We also ask that criticism be accompanied by suggestions for improvement and offers of assistance.

I am grateful for all of the suggestions and offers of help that I have received, particularly from the past presidents. I assure you that I will not let your generous offers of service go unaccepted nor your wisdom and experience go unheeded. I hope to use every resource available to build upon the fine foundation that our past leaders have established.

There are several areas where we will stress communications, they are:

1. Legislature — The MPhA must be proactive in legislative matters. We need to develop a legislative strategy early and give all professionals in the state the opportunity to communicate their views and build support. We need to be ready to contact our lawmakers soon after they are elected. Any pharmacist who knows a legislator can help here. We must maintain the role of implementors — not defenders.
2. Policy — Policy is interpreted by the Board of Trustees and implemented by the staff and membership. Policy is made in the House of Delegates. Today we heard about a dozen resolutions. Almost all of the resolutions were adopted. I hope that members will continue to submit proposed resolutions in the future with the same enthusiasm that they did for this session.
3. Committees — Members have an opportunity to express their views in committees. Recently, we asked all members interested in being on committees to make their intentions known to the office. In a very short while, we will be making our committee selections. Remember, this is your chance to affect Association operations and communicate your needs and interests.
4. Local Associations — At this Convention, several of your State officers met with the presidents of local associations. It is our hope to assist the local associations to build interest and enthusiasm among their members. We are also planning to coordinate our activities to minimize conflicts in events. It is unfortunate that there was no representation at this Convention from many counties in the State. Local associations are essential to a strong state association. The MPhA's lobbying efforts in Annapolis can be reinforced six times by representatives speaking for six separate organizations from all over the state. We can be much more successful in mustering support by coordinating our influence.

Several other State institutions solicit your views and encourage communication. They are:

- The Board of Pharmacy
- The Continuing Education Coordinator Council
- The Tripartite Committee, which is composed of the Professional Associations, the Board of Pharmacy and the University of Maryland, School of Pharmacy. This committee welcomes suggestions on how to unify pharmacy on issues facing us in this state.

These are just a sample of areas where individual pharmacists can be heard. I know for a fact that there is no such thing as a lonely voice in the wilderness. Over the years, I have seen that every concern of every member that is communicated receives consideration by your officers.

Let's not only continue to communicate, but let's increase our communication.

(delivered at the annual Convention banquet)

Philip Cogan,

PRESIDENT



Women In Pharmacy



by
Jackie Collins

As women are gaining independence and self-confidence, they are moving out into major professional fields within the health care system. Pharmacy is no exception to this fact. The pharmacy profession now has the highest percentage of women of the eight major health fields, including medicine, dentistry, and veterinary medicine.¹ As to this writer's feeling concerning women in pharmacy, the old adage comes to mind, "Better late than never!"

For centuries, women have been excluded from major health professions including pharmacy. Ironically, pharmacy practice began in the home with the practitioners being none other than women. However, in the early 1700's the practice was removed from the home and so taken away from women with the development of community pharmacies. Subsequently, pharmacy schools and organizations were founded, but these restricted admission to those who had graduated from college. This resulted in excluding women from pharmacy until the late 1800's. The turning point, however, came with the forced reversal of the decision by the Kentucky Board of Pharmacy to refuse its examination to women.² Financial difficulties in owning and operating pharmacies restrained women's progress for several more years; however, the door had finally been unlocked. Presently, with the movement for equal rights by and for women, females are striving to reach higher aspirations than ever before. The employed woman is no longer the abnorm, but is the norm in our society.

With the influx of women into the profession, several studies concerning women and pharmacy have been made. There are, however, several flaws in many of the studies including assumptions that male pharmacists all have full-time employment, and failure to obtain similar studies on males to be used as comparisons.³ Two types of studies place responsibility for women's work position and behavior on personal characteristics. May I point out that women are different from men, but are by no means inferior. The difference may add the necessary ingredients that pharmacy has been lacking through the years. Other studies paint clearer pictures by considering "how the social as well as economical conditions for the specific work situation affect the decisions and behavior of workers rather than placing the burden of explanation on nonwork factors such as the home or personalistic traits."⁴ An important ingredient for any person's drive to do a job is the encouragement to do so. "Women are much more likely to remain employees while their male counterparts move up into administrative and ownership positions."⁵ Many employers are discrimina-

tory to females because they perceive a stereotypical woman as having a high turnover rate and being undependable. Therefore, females are treated as temporary help, not deserving of time and encouragement because of their perceived short period of employment. The major concern for any employer should be over the competence with which a pharmacist practices the profession and the contribution she makes to improving standards within the profession, not the number of hours she works per week. It is hard to believe that nineteenth century ideas still exist. The fact, however, remains that these ideas do exist and in order to create a feeling of belonging for all females, the work situation must be modified.

Experts in the field of pharmacy fear the rapid involvement of females in this profession. Among their greatest fears are dropout rates and problems associated with other female-dominated professions such as nursing. Women today have more desires and needs to fulfill than in the past. "The traditional role of wife and mother continues, but work outside the home has increased markedly."⁷ As women are gaining independence, they are rejecting traditional roles, such as housewife, of the past. Women are influenced by the same age and life cycle variables that affect men's job ambitions and commitments.⁸ Furthermore, married men and women more often than not share child rearing tasks, enabling the woman to work on a full-time basis. Married women with children continue to work, if not out of desire, out of economic necessity. With the rise of inflation, it is very difficult for a family to live on only one income. Inflation is also the cause for many women's decisions against having children at all. For these reasons, the dropout rate is now leveling off.⁹ Therefore, one can not look at the past to predict the future.

Many female-dominated professions have problems with under-employment, unemployment, and low wage employment (all associated with overcrowding). So, these are fears that experts have voiced concerning women in pharmacy, particularly the field of clinical pharmacy.¹⁰ However, it seems reasonable that if such problems can be anticipated, then they can be controlled early and major problems can be avoided. This can be accomplished by informing and encouraging students into the many different areas of pharmacy open to them.

Although the experts fear the growth of female involvement in pharmacy, many feel that women have much to offer the profession. I previously stated that pharmacy has been lacking in certain areas over the years. These areas include pharmacist-patient contact and increased total involvement by the pharmacist (i.e. those concepts now being taught to

^{***}Jackie Collins is a third-year student at the University of Maryland School of Pharmacy.

pharmacy students). It is felt that women are better qualified for this due to their natural instinct to nurture, and to encourage growth and healthy human development. Women show more empathy and sensitivity to others; they are more involved in the caring function of pharmacy. In a study by Kirk et al, female students revealed a vocational interest profile similar to nursing, whereas males showed a profile more similar to that of morticians.¹¹ These results showed that females are more interested in the patient care aspect, that which is now being professed to pharmacy students across the country.

Women are making their move into health care professions. This can be extremely beneficial to the health care team if problems are anticipated and corrected early. Instead of viewing this change as an invasion, the influx should be seen as reinforcements for the team. Working together, men and women can aid the pharmacy profession in attaining goals of good patient care.

ENDNOTES

- 1 Lear, Aron H., R.Ph., Women in Pharmacy. The Apothecary, 91 (25):25; 1979 March/April.
- 2 Ibid; p. 39.
- 3 Kronus, Carol L., Women in Pharmacy: Trends, Implications and Research Needs. Journal of the American Pharmaceutical Association, NS17 (11): 678; 1977 November.
- 4 Ibid; p. 678.
- 5 Ibid; p. 675.
- 6 APhA Task Force on Women in Pharmacy: Summary Report, Presented to the APhA Annual Meeting, March 29, 1981 in St. Louis, p. 6.
- 7 Ibid; p. 2.
- 8 Ibid; p. 677.
- 9 Kronus, Carol L., Op.Cit., p. 677.
- 10 Ibid; p. 675.
- 11 Goyan, Jere. On the Emergence of Women in Pharmaceutical Education. American Journal of Pharmaceutical Education, 43:300, 1979 August.



Jackie Collins

APhA Task Force Recommendations

At its Annual Meeting on March 29, 1981, the A.Ph.A. accepted a report of the Task Force on Women in Pharmacy. The Task Force Committee included Estelle Cohen, the Consumer member on the Maryland Board of Pharmacy. A copy of the complete report is available from the Association office. The major recommendations of the report are summarized below.

1. An Office of Women's Affairs should be established by APhA.
2. The profession of pharmacy must develop a mechanism for gathering and reporting annual manpower data on practicing pharmacists.
3. Women pharmacists should insist they be paid equally with men for equal work and responsibility, and men pharmacists must encourage and support this expectation.
4. State pharmacy organizations should make a long-term commitment to getting women pharmacists actively involved in their committees and to ensuring that women pharmacists are encouraged to seek out elected offices and other leadership positions.
5. Each state association should give strong consideration to forming its own task force on women in pharmacy with representation of both men and women pharmacists.
6. Qualified women pharmacists should be encouraged to seek out ownership or management positions in their practice environments so they can be more influential in determining the future standards of pharmacy practice.
7. Efforts should be made to encourage more women pharmacy graduates to continue their education in graduate or advanced professional degree programs.
8. Efforts should be made to encourage more women pharmacy graduates to pursue careers in pharmacy education as tenure track faculty members in the clinical, administrative and basic science areas.
9. Representatives from the pharmaceutical industry must take the initiative to make pharmacy school faculty more aware of the expanded career opportunities that are available to pharmacy school graduates. Likewise, pharmacy school faculty, through an active career counseling program, must take the initiative to make students aware of these opportunities.
10. Schools of pharmacy should take a serious look at the nature and extent of career guidance they make available to their students and take steps that ensure their faculties are accurately informed about the career options open to a pharmacy school graduate. Guidance in career preparation should be an ongoing component of a school's counseling program.
11. Recruitment materials for the profession should be updated to stress a more career-oriented role for women and to minimize the focus on opportunities for part-time employment.
12. Advertisements via any media in which a pharmacist is presented or depicted should use a woman on a regular basis to represent the pharmacist.

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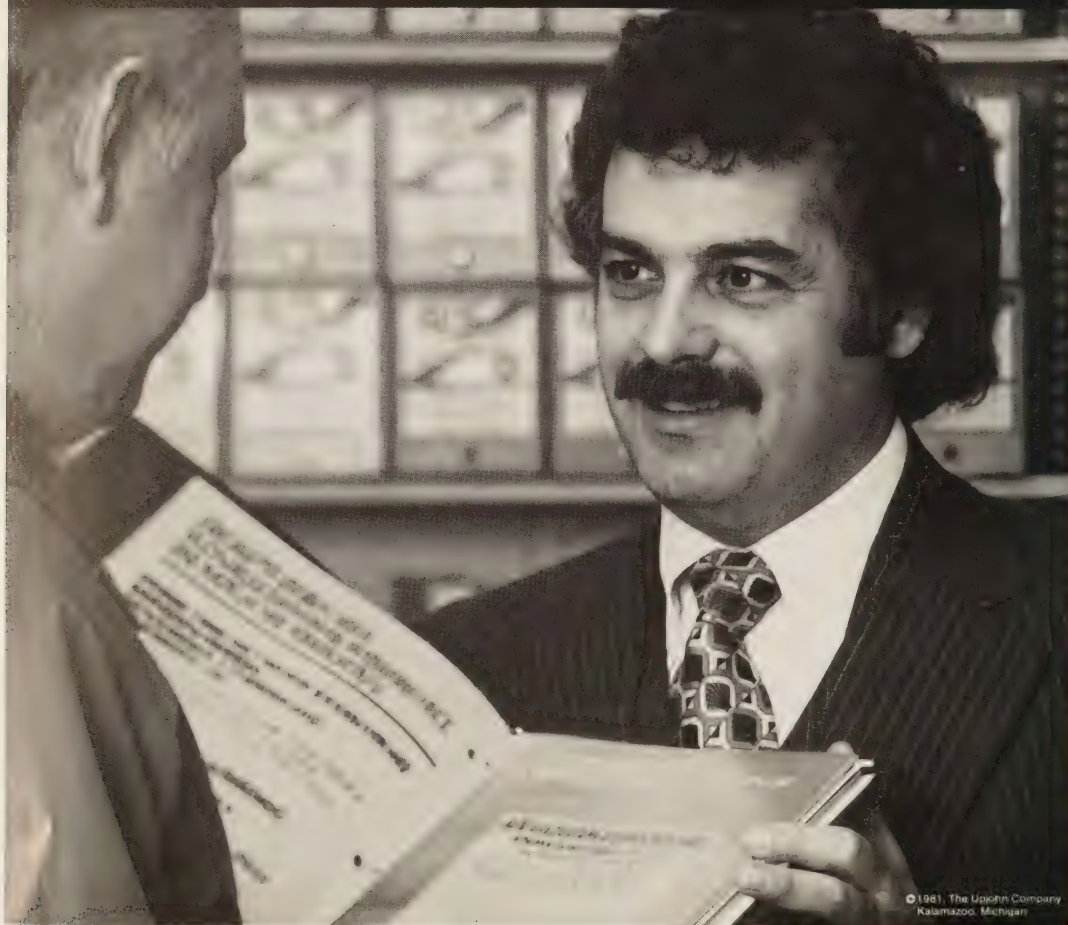
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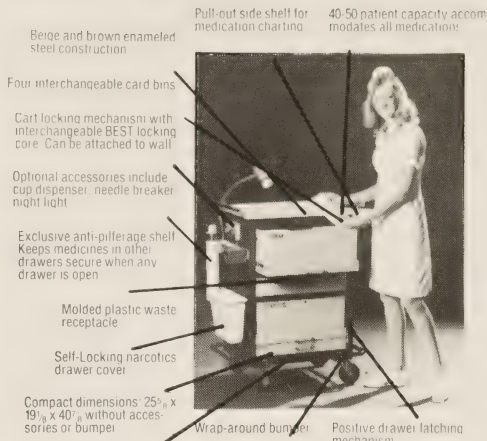
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Doc Sterling . . .

The end of an era

by
Lila Line

Elmer Watson Sterling, well-known pharmacist who had operated a drug store in Church Hill, Md., from 1920 to 1980, died on April 26, 1981. He was 87.

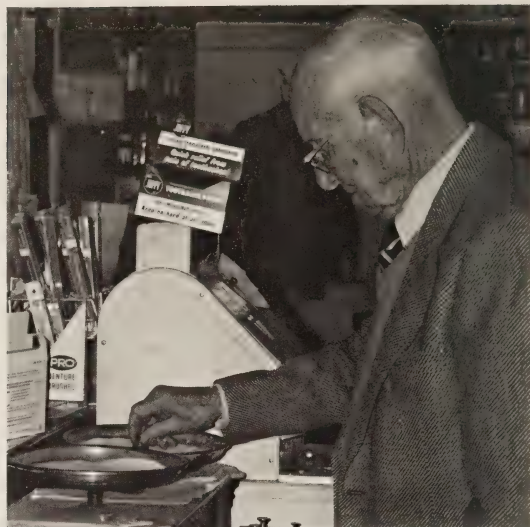
Last June after 60 years of owning and operating one of the oldest continually running pharmacies in the nation, "Doc" Sterling locked his doors for good. It wasn't that he wanted to retire, but people just didn't come into the old store anymore. With the larger chain drugstores that opened up over the past few years in nearby towns, people were getting into the habit of bypassing Sterlings for the supermarkets. Besides, he was getting on in years, 87 come September, and his health wasn't as good as it once was.

"It was a hard decision to make", Sterling told this reporter about a year ago. "I never wanted to quit work. That was my social life. People used to come to the store to visit. We don't see many people these days. They don't come easy to somebody's home." His wife Rebecca interjected: Most of our friends are gone now."

Yes, most of their friends are gone, and now Elmer Watson Sterling is gone and E. W. Sterling-Drugs, a drugstore that served the people of Snow Hill for over 115 years, is also gone. It's as if it's the end of an era — a slower paced era when customers and friends visited in the "parlor" of the old wooden drugstore, where folks sat in several antique chairs while recounting stories, sometimes the same stories told over and over again, and the Sterlings would nod their heads and smile as they listened intently as if they hadn't heard them before. Along the back wall in the parlor were photographs of his mother and father, his grandparents, an etching of nudes and two old-fashioned watercolors of rural scenes that once belonged to a favorite aunt.

At one time the old drugstore had a fountain, one of the most popular spots in town, says Mrs. Sterling, who made all the food at home, including hams that became so famous that truckers and other travelers made it a point to stop there for sandwiches. But what made the fountain boom, she says, was her husband's homemade chocolate syrup. Their three daughters took turns over the years working behind the fountain making sandwiches from their mother's hams and sodas from their father's syrup.

Rebecca Sterling is a small woman who could have been a beauty queen in her day. Even at 81 she is still exceptionally pretty, with smooth, pink cheeks and dancing blue eyes. There's still a skip in her quick step though not as quick since



Doc Sterling weighs ingredients on old scale that was in the drugstore when he purchased it. The scale was given to one of his daughters when he closed up shop.

her husband's recent illness and passing which has affected her usual jubilant nature.

The old drug store in Church Hill was first opened in 1895 by a Dr. S.C. Dudley one of three physicians who once tended the needs of the people of Church Hill. Now there are none. Preferring to spend more time with his patients, Dr. Dudley put the pharmacy up for sale in 1920. A fellow named Johnson bought the store but since Johnson had no pharmaceutical license, the state inspectors "closed him down." A Parke-David traveling salesman told Doc Sterling about the pharmacy being for sale. He had been working at the time at a brother's drugstore in nearby Chestertown. He got to Church Hill as fast as he could, but the problem was, he didn't have a cent. On top of that, the bank refused to lend him a nickel.

As it turned out, a gentlemen farmer from Hillsboro named Charles Stewart who had never met Sterling, bought two \$1000 notes. Sterling thought that was a great compliment to buy the notes from him even though he had never seen him. Soon afterward, the bank bought a note for \$800. He was in business. Three months after the date of his grand opening on June 1, 1920, Elmer Watson Sterling married his Chestertown sweetheart, the former Sarah Rebecca Bennett. Oddly enough, his mother's maiden name was Rebecca Sarah Bennett. The two were not related.



The old drug store as it appeared two years ago.

Dr. Dudley continued to own the building that the drugstore was in, but when he died a few years later, Sterling had to buy it to keep the drugstore. In 1926, he bought the entire three story building for \$5000.

Until it was sold last summer, E. W. Sterling-Drugs looked much the same as it did during those early years. Hugh, dark wooden floor-to-ceiling cases lined the long walls, and several small glass cases stood in the middle of the store. On a top shelf were remedies as old as the building itself, such as: Dr. Caldwell's Senna Laxative Syrup Pepsin; Jacques' Little Wonder Capsules; Dr. Thomas Ecectic Oil; Inner-Aid Laxative, Medicine of Genuine Merit; and Hamlins Wizard, Oil Liniment. When they sold the store in June, nearly everything was sold, mostly to collectors and antique dealers, except for special items that were given to the Sterling's children.

"I think there are some things that should stay in the family," says Rebecca Sterling.

Doc Sterling was proud of his heritage. His mother's father was James Bennett. He and his brother were the most famous blockade runners in Virginia during the Civil War. They'd buy stuff and take it over to General Lee's forces on the Western Shore. The Yankees were always trying to catch his grandfather. They had him two or three times, but he was slick enough to get away. Finally toward the end of the war, the Yankees grabbed his grandmother, and put her in the Eastville jail because she wouldn't tell where his grandfather was. When she got out of jail, she died of childbirth, and it was said that the jailing was what killed her. His grandmother had five girls and a boy, and since his grandfather couldn't take care of the children, they were farmed out to different families until they became adults. That's how things were done in those days. Later, his aunt, his mother's sister, Missouri Bennett, left Virginia and move to Crisfield, Md. His mother went for a visit and stayed. She married his father, William Sterling, a waterman. Doc Sterling was born and raised in Crisfield, along with brothers Willie and Alonzo, and sisters, Ratio and Ollie. They're all gone now.

Sterling left Crisfield a few days after he was graduated from the ninth grade because he didn't want to be a crabber or an oysterman. The ninth grade was the last grade of high school in those days. The summer before he left, he'd met a

man by the name of Tibetts who had a camp at Lake George, N.Y. He picked him out a crowd playing baseball and asked if he wanted to go to Lake George for the summer. That got him away from Crisfield and he saw a different world out there. Then he knew he wanted to do something else besides working on the water and living in Crisfield.

So he left Crisfield after high school, boarding a steamboat named "Old Eastern Shore" for the overnite trip to Baltimore. Fare was 50 cents and you could sleep on beds in the hold for nothing. They had staterooms, but they were too expensive. He had \$1 dollar in his pocket and a bible. When he got to Baltimore he contacted a fellow he had met while working at Lake George, and by 8 a.m., he had a job at Blooms Candy Factory. After several other jobs, he made up his mind he wanted to be a pharmacist, so in 1917, he entered the University of Maryland's School of Pharmacy. Working in drugstores, he earned 50 cents a week. That, plus a small amount sent him by his father, paid for his schooling. The owner of the drugstore told him if he wanted to keep us out of the war to vote for Wilson. So he voted for Wilson. The next spring, he was in France. He was due to leave for the front the day the Armistice was signed.

When he returned home in 1919, he worked another summer and fall for his brother Alonzo at Sterling's Drugstore in Chestertown before deciding to take a short pharmacy course at the Max Morris School of Pharmacy in Macon, Ga., which he attended three months, 16 hours a day. He took the State Board in Atlanta. He later took and passed the reciprocal examination in Maryland, so when the pharmacy became available in Church Hill in 1920, he was ready.

During the time he ran the drugstore, Sterling also served as Church Hill's Postmaster for 13 years, under Presidents Hardings, Coolidge and Hoover. In addition, he was chairman of the state Republican Party for 20 years. A staunch Republican, he once ran for the Senate and carried one of the districts in this most solidly Democratic county.

Queen Anne's County has far from forgotten Doc Sterling. One of six out of 18,000 residents to receive an award, Doc Sterling was honored by a proclamation presented to him at a recent ceremony. It reads: PROCLAMATION. The Commissioners of Queen Anne's County record with admiration and appreciation the outstanding contributions of Dr. Elmer W. Sterling by service rendered to fellow countians as Outstanding Citizens during the period of 1920 to 1980. Presented in grateful recognition and spread upon the minutes of Queen Anne's County, Maryland, this 2nd day of May 1980."

No, Doc Sterling is gone but not forgotten, still the main street at Church Hill will never look just right without the E. W. Sterling Drugs sign swinging in the fall breeze. And somehow there's a distinct feeling that this is indeed the end of an era.

EDITOR'S NOTE: Until his death Elmer Sterling was the oldest living Past President of the Association and an Honorary Life Member. At the June Convention the Association adopted a resolution honoring his contributions to the profession.

Maryland Labor Organizations

For Your Information From The Third Party Committee

COUNCILS

Baltimore Build & Construction Trades Council
5907 Harford Rd., Balto., MD 21214

PHONE
426-9415

Baltimore Port Maritime Council
1216 E. Baltimore St., Balto., MD 21201

327-4900

Central Maryland Labor Council
18 W. Franklin St., Hagerstown, MD 21740

739-9500

Delmarva Peninsula Central Labor Council
1323 N. Salisbury Blvd., Salisbury, MD 21801

749-9212

Laborers' District Council of Baltimore & Vicinity
4603 York Rd., Balto., MD 21212

532-6555

Maryland State & D.C., AFL-CIO
93 Main St., 2nd fl., Annapolis, MD 21401

269-1724

Metropolitan Baltimore Council of AFL-CIO
2701 W. Patapsco Ave., Balto., MD 21230

242-1300

Washington D.C. Building & Construction Trades Council
3601 Hamilton St., Hyattsville, MD 20782

277-0870

Western Maryland Central Labor Council
Algonquin Motor Inn, Cumberland, MD 21502

777-1820

AIR TRAFFIC CONTROLLERS

Professional Air Traffic Controllers Organization
Local 213
P.O. Box 8731, Balto., MD 21240

ASBESTOS WORKERS

Association of Heat & Frost Insulators & Asbestos Workers

Local 11 — (Asbestos/Insulators)
607-609 North Duncan St., Balto., Md. 21205 732-5478

AUTO WORKERS

United Auto Workers
Region 8

E. T. Michel
International Executive Board & Director
7124 Ambassador Rd., Balto., MD 21207 298-4647

Local 141 — (Rebuilds diesel & turbo engines)
United Automobile, Aerospace & Agricultural Implement Workers of America
7124 Ambassador Rd., Balto., MD 21207 265-8800

Local 171 — (Truck manufacturing)
United Automotive, Aerospace & Agricultural Implement Workers of America
Rt. #6, Box 239-B, Hagerstown, MD 21740 733-6932

Local 239 — (Auto assembly)
1010 S. Oldham St., Balto., MD 21224 276-8789

Local 354 — Manufacture of gasoline dispensing equipment & automotive hoists)
United Automobile, Aerospace & Agricultural Implementation Workers of America
124 College Ave., Salisbury, MD 21801 749-8896

Local 738 — (Aerospace)
United Automobile, Aerospace & Agricultural Implementation Workers of America
1515 Martin Blvd., Balto., MD 21220 686-9292

Local 842 — (Aerospace — sand blasting)
16-1/2 W. Franklin St., Hagerstown, MD 21740 739-3090

Local 1247 — (Mack trucks)
138 W. Washington St., RM. 405, Hagerstown, MD 21740 733-0462

United Auto Workers, Agricultural Implement Workers of America
1999 Pennsylvania Ave., Hagerstown, MD 21740

CEMENT MASONS

Operative Plasterers & Cement Masons International Association of U.S. & Canada

Local 43 — (Operative Plasterers & Cement Masons Association of Baltimore & Vicinity)
2101 Barclay St., Balto., MD 21218 243-8255

CHEMICAL WORKERS

International Chemical Workers Union

Local 2
500 E. Patapsco Ave., Balto., MD 21225 355-8551

Local 217
6608 Holabird Ave., Balto., MD 21224 633-2056

Local 860
4623 Falls Rd., Balto., MD 21204 426-7394
241 Grindall St., Balto., MD 21230 752-7583

Local 1490 — (Building modular homes)
United Automobile, Aerospace & Agriculture Implement Workers of America
7124 Ambassador Rd., Balto., MD 21207 265-8800

BAKERY, CONFECTIONERY & TOBACCO WORKERS

Bakery, Confectionery & Tobacco Workers International Union
(Production & Maintenance)
10401 Connecticut Ave., Kensington, MD 20795 933-8600

Local 68
2701 W. Patapsco Ave., Balto., MD 21227 242-1677

BOILERMAKERS

International Brotherhood of Boilermakers, Ship Builders, Blacksmith & Helpers

Local 193
International Brotherhood of Boilermakers
1101 W. Patapsco Ave., Balto., MD 21230 355-2344

BRICKLAYERS & ALLIED CRAFTSMEN

Bricklayers & Allied Craftsmen International Union
Local 1
828 Dulaney Valley Rd., Balto., MD 21204 828-6244

Local 6 — D.C.
3415 Windom Rd., Brentwood, MD 20722 227-7900

Local 6 — M.D.
513 Frederick St., Cumberland, MD 21502 724-1069

CARPENTERS & JOINERS

United Brotherhood of Carpenters & Joiners of America
Local 9 L — (Lanthers)
4410 Stamp Rd., Washington, D.C. 20031 889-2210

Local 101 — (Carpenters)
2701 W. Patapsco Ave., Balto., MD 21230 646-0100

Local 340 — (Construction & Industrial)
18 N. Franklin St., Hagerstown, MD 21740 733-4930

Local 1548 — (Millwrights & Machinery Erections)
2701 W. Patapsco Ave., Balto., MD 21230 646-0100

Local 2012 — (Carpenters & Millwrights)
P.O. Box 44, Seaford, DE 19973 (302)629-8747

R.D. #2, Box 328C, Seaford, DE 19973 (302)629-7692

CEMENT, LIME, & GYPSUM WORKERS

United Cement, Lime & Gypsum Workers International Union
Local 388

103 A. St., Brunswick, MD 21716
2145 Main St., Northampton, PA 10814 (215)262-7806

CLOTHING & TEXTILE WORKERS

Amalgamated Clothing & Textile Workers Union Eastern Shore Joint Board

1323 N. Salisbury Blvd., Salisbury, MD 21801 749-9212

Celanese Local 1874

418 N. Centre St., Cumberland, MD 21502 724-3550

International Ladies Garment Workers Union

Local 110

1 N. Howard St., Balto., MD 21201 685-0884

Local 239

1 N. Howard St., Balto., MD 21201 685-0884

COMMUNICATION EQUIPMENT

Communication Equipment Workers, Inc. (Ind.)

7500 Eastern Ave., Balto., MD 21224 284-2807

COMMUNICATION WORKERS

Communication Workers of America

Maryland State Office

7133 Rutherford Rd., 4th Fl., Balto., MD 21207 298-8000

Local 2100

P.O. Box F, Chase, MD 21027 335-2100

Local 2101

5405 York Rd., 2nd Fl., Balto., MD 21212 435-3900

Local 2108

10 Old Post Office Rd., Silver Spring, MD 20910 585-4084

United Telegraph Workers International

701 Gude Dr., Rockville, MD 20850 762-4444

DISTILLERY WORKERS

Distillery, Wine & Allied Workers International Union

Local 22

1216 E. Balto. St., Balto., MD 21202 276-4973

Local 34

1335 Linden Ave., Arbutus, MD 21227 242-2966

ELECTRICAL WORKERS

International Brotherhood of Electrical Workers

Local 24 — (Electrical Construction)

2701 W. Patapsco Ave., Balto., MD 21230 247-5511

Local 26 — (Construction, Sign & Motor Repair)

6220 Kanas Ave., N.E., Washington, D.C. 20011 829-2900

Local 70 — (Outside Electrical)

3405 Bonita St., S.E., Rm. 218, Wash., D.C. 20023 899-2272

Local 307 — (Construction electrical)

Algonquin Motor Inn, Rm. 608-610,
Cumberland, MD 21502 724-3403

Local 1200 — (Radio, Television Broadcasting)

2401 Blueridge Ave., Rm. 405, Wheaton, MD 20902 933-0450

Local 1501 — (Manufacturing & servicing of pari-mutuel equip. & lottery)

P.O. Box 5470, Towson, MD 21204 823-2435

Local 1800 — (Manufacturing wire cable)

1812 Appleton Rd., Elkton, MD 21921 398-9027

Local 1805 — (Electric manufacturing & small motor re- pair)

407 Crain Hwy., Rm. 203, Glen Burnie, MD 21061 761-7780

International Union of Electrical, Radio & Machine Workers

Local 109

Taylor Ave., Balto., MD 21234 665-7147

2316 Foster Ave., Balto., MD 21234

Local 130

1335 Linden Ave., Balto., MD 21227 247-1233

ELEVATOR CONSTRUCTORS

International Union of Elevator Constructors

Local 7

7905B Harford Rd., Balto., MD 21784 661-1491

ESSO INDUSTRIAL EMPLOYEES

Esso Industrial Employees' Union

Local 1 — (Drivers, warehouse, & terminal operations)

3406 Curtis Dr., Hillcrest Heights, MD 20023 423-4428

FIRE FIGHTERS

International Association of Fire Fighters

Md. State & D.C. Professional Fire Fighters

305 W. Monument St., Balto., MD 21201 539-8229

Local 964

Baltimore Fire Officers Association

305 W. Monument St., Balto., MD 21201 752-1839

Local 1311

Baltimore County Fire Fighters Association

P.O. Box 7828, 838 Eastern Blvd., Balto., MD 21221 682-3412

Local 1619

Prince George's County Professional Fire Fighters

3106 Mitchellville Rd., Bowie, MD 20716 262-1020

Local 1664

Montgomery County Fire Fighters Association

170 Rollins Ave., Suite 203, Rockville, MD 20852

Business Agent

Local 1742

B.W.I. Airport, Balto., MD 21240 787-7077

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United Food & Commercial Workers Union

Local 117 — Meat, Poultry, Seafood & Allied Workers)

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5901 Harford Rd., Balto., MD 21214 426-7700

Local 392 — (Sugar Workers)

1425 Woodall St., Balto., MD 21230 539-2483

Local 400 — (Retail Store Clerks)

4301 Garden City Dr., Landover, MD 20785 459-3400

Local 692 — (Retail Store Clerks)

305 W. Monument St., Balto., MD 21201 837-8500

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United Furniture Workers

Local 75A — (Metal Fabrication/Draperies Hardware)

27 East North Ave., Balto., MD 21202 837-0574

GLAZIERS

International Brotherhood of Painters & Allied Trades

Local 963 — (Glass & Metal)

Glaziers Local Union

5101 Branchville Rd.,
College Park, MD 20740 345-7400

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American Federation of Government Employees

Local 331

P.O. Box 125, V.A. Medical Ctr.,

Perry Point, MD 21902 642-6036

Local 383 — (D.C. Government Employees)

3360 Center St., Laurel, MD 20810 725-3368

Local 1622 — (Federal Civilian Employees)

P.O. Box 82, Odenton, MD 21113 569-4585

Local 1923

6401 Security Blvd., Rm. 1-J-21,

Operations Bldg., Balto., MD 21235 594-7238

Local 2084 — (Hospital-Veterans Hospital)

3900 Loch Raven Blvd., Balto., MD 21218 235-0393

Local 2146

Ft. Howard, V.A.M.C., Ft. Howard, MD 21052 477-1800

American Federation of State, County & Municipal Em- ployees

Council 67

305 W. Monument St., Balto., MD 21201 837-7278

Council 92

Md. State Employees Council

305 W. Monument St., Balto., MD 21201 N/A

Assembly of Governmental Employees

Md. Classified Employees Association

2205 N. Charles St., Balto., MD 21218 235-4501

Association of Civilian Technicians (Federal employees)

348A Hungerford Dr., Rockville, MD 20850 762-5656

Classified Municipal Employees Association

(Public Sector — Baltimore City)
18 Guilford Ave., Balto., MD 21202

547-1679

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(202)871-7963

Local 42-B

3018 Hamilton St., Hyattsville, MD 20782

559-0800

Local 144-B

3001 Hamilton St., Hyattsville, MD 20782

559-9300

Local 348

3100 E. Monument St., Balto., MD 21205

675-0655

GUARDS**Independent Watchmen's Association**

Local 1852 — (Guards & watchmen/ships & piers/Port of Baltimore)
33 S. Gay St., Balto., MD 21202

HOSPITAL & HEALTH CARE EMPLOYEES**Laborers' International Union of North America****Local 1273** — (Hospitals, Nursing Homes, Health Centers)

Hospital Employees

317 N. Paca St., Balto., MD 21201

837-1273

2002 Clifwood Ave., Balto., MD

563-4388

National Union of Hospital & Health Care Employees**District 1199E**

305 W. Monument St., Balto., MD 21201

547-8300

HOTEL & RESTAURANT**Hotel & Restaurant Employees & Bartenders International Union****Local 25** — (Lodging, Food & Beverage)

1003 K. St., 7th Floor,

N.W., Washington, D.C. 20001

(202)737-2225

Local 36 — (Bartenders, waiters, waitresses, housekeeping & cafeteria)
302 W. Monument St., Balto., MD 21201

728-5500

INSURANCE WORKERS**Insurance Workers International Union****Local 3** — (Life Insurance Agents)

5714 McCormack Ave., Balto., MD 21206

866-1607

IRONWORKERS**International Association of Bridge, Structural & Ornamental Ironworkers****Local 5**

1357 New York Ave., N.E., Wash., D.C. 20002

(202)832-4420

Local 486

2373 Rhode Island Ave., N.E., P.O. Box 10115,

Washington, D.C. 20018

(202)832-8575

Local 568

Baltimore & Greene Sts., Cumberland, MD 21502

777-7433

LABORERS**Laborers' International Union of North America**

Laborers' District Council of Baltimore & Vicinity

4603 York Rd., Balto., MD 21212

532-6555

Local 194 — (Building Construction)

317 N. Paca St., Balto., MD 21201

539-1238

Local 456

3217 12th St., N.E., Wash., D.C. 20017

(202)635-8429

Local 516 — (Construction)

4603 York Rd., Balto., MD 21212

532-6586

Local 707 — (Construction & general laborers)

P.O. Box 11209, Balto., MD 21239

433-6449

Local 832 — (Construction & general laborers)

P.O. Box 603, Prince Frederick, MD 20678

535-3100

LAUNDRY & DRY CLEANING**Laundry & Dry Cleaning International Union****Local 195**

1511 N. Chester St., Balto., MD 21213

N/A

LETTER CARRIERS**National Association of Letter Carriers**

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				Local 669 — (Road Sprinkler Fitters) 7411 Riggs Rd., P.O. Box 773, Adelphia, MD 20783		439-7300
				Local 769 — (Plumbers & Pipefitters) 1870 Franklin St., P.O. Box 357, Hagerstown, MD 21740		733-2584
				PLUMBERS & STEAMFITTERS United Association of Plumbers & Steamfitters Local 489 — (Plumbers & Steamfitters) Algonquin Hotel, Rm. 504-505, Cumberland, MD 21502		722-8515
				Local 602 — (Steamfitters) 809 Maryland Ave., N.E., Wash., D.C. 20002		(202)544-6100

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Washington, D.C. 20002 (202)547-2420

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310-B Tower Bldg., 222 E. Balto. St., Balto., MD 21202 685-1863

Local 481 — (Printing)
Printing Specialists & Paper Products Union
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R.D. #2, Box 560, Ridgely, W. VA 26753 (304)738-3289

Local 80
Composition Roofers Local
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United Rubber, Cork, Linoleum & Plastic Workers of America

Local 26
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Federation of Westinghouse Independent Salaried Unions

Salaried Employees Association
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School Employees Union

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7610 Penn Ave., Suite 305, Forestville, MD 20028 736-8400

SCHOOL TEACHERS

American Federation of Teachers

Local 340
Baltimore Teachers Union
2533 St. Paul St., Balto., MD 21218 243-0353

Local 1670
Montgomery County Federation of Teachers
3925 Pylers Mill Rd., Kensington, MD 20795 933-5175

Local 2150
Prince George's County Federation of Teachers
8235 Penn Randall Pl., Suite 103,
Upper Marlboro, MD 20870 736-8777

Public School Teachers Association of Baltimore City
(Affiliate of MSTA & NEA)
106 E. Chase St., Balto., MD 21202 539-2505

SHEET METAL WORKERS

Sheet Metal Workers International Association

Local 122
4705 Erdman Ave., Balto., MD 21205 732-1849

STEELWORKERS

United Steelworkers of America

Local 2609 — (Steel Manufacturing)
550 Dundalk Ave., Balto., MD 21224 633-9220

Local 2610 — (Steel Manufacturing)
540 Dundalk Ave., Balto., MD 21224 633-7400

Local 3016 — (Can Makers)
Unity Hall, 1718 Dundalk Ave., Balto., MD 21224 633-8141

Local 3164 — (Production of welding wires)
North Point Blvd., Sparrows Pt., MD 21219 477-3300
220 Dunkirk Bldg., Dundalk, MD 21222 288-3200

Local 3185 — (Steel-making operations)
3127 E. Monument St., Balto., MD 21205 276-8717

Local 5267 — (Manufacturing of cans)
1717 Broening Hwy., Balto., MD 21224 633-6546

Local 5977 — (Heavy Metals)
P.O. Box 357, Riviera Beach, MD 21122 255-8133

STOVE, FURNACE & APPLIANCE WORKERS

Stove, Furnace & Allied Appliance Workers International Union of North America

Local 50 — (Manufacturing commercial cooking equipment)
3600 North Pt. Blvd., Balto., MD 21222 284-0660

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International Brotherhood of Teamsters

Teamsters Joint Council 62
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Local 33 — (Bakery, Laundry & Allied Sales Drivers)
2120 Bladensburg Rd., N.E., Suite 204,
Washington, D.C. 20018 (202)526-2033

Local 67 — (Brewery, Beverage & Vending)
2120 Bladensburg Rd., N.E., Wash., D.C. 20018 (202)526-3600

Local 246 — (Dairy Delivery & Plant Processing, Court Personnel, Bank Appliance Service, Related Clerical Employees, Public Law Enforcement Personnel)
2120 Bladensburg Rd., N.E. Wash., D.C. 20018 (202)526-1070

Local 311 — (Petroleum, Construction, Tanklines Drivers & Allied Employees)
1005 North Pt. Blvd., Suite 725,
Balto., MD 21224 284-6200

Local 33 — (Brewery, Yeast, Soft Drink Workers & Drivers, Salesmen, Amusement & Vending Service Men & Allied Workers)
2319 Maryland Ave., Balto., MD 21218 467-1543

Local 355 — Truck Drivers, Helpers, Taxicab Drivers, Garage Employees & Airport Employees)
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Local 453
200 S. Lee St., Cumberland, MD 21502 722-5720

Local 557 — (Freight Drivers & Helpers)
6000 Erdman Ave., Balto., MD 21205 485-9200

Local 570 — (Warehouse Employees) 205 E. Patapsco Ave., Balto., MD 21225	354-1310
Local 590 — (Warehouse & Retail Employees) 2725 Washington Blvd., Balto., MD 21230	525-1044
Local 876 — (Chauffeurs, Warehousemen & Helpers) 1323 N. Salisbury Blvd., Salisbury, MD 21801	742-3144
Local 937 — (Milk, Ice Cream, & Dairy Employees) 4303 Harford Rd., Balto., MD 21214	254-9377
Local 992 — (Teamsters, Chauffers, Warehousemen & Helpers) 109 S. Potomac St., Hagerstown, MD 21740	739-7550
Local 1010 — (Brewery Workers) 6910 Eastern Blvd., Balto., MD 21224	282-0400

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American Federation of Television & Radio Artists 35 Wisconsin Circle, Washington, D.C. 20015	657-2560
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Local 1300 — (Transit Drivers & Maintenance Personnel) 112 W. 25th St., Balto., MD 21218	889-3566
2806 Kirkleigh Rd., Balto., MD 21222	282-8925

Maryland Paper Wins AACP Award

The Board of Directors of the American Association of Colleges of Pharmacy has selected —

Validation of Written Simulations as Measures of Problem Solving for Pharmacy Students, David S. Roffman, Dianne E. Tobias and Stuart M. Speedie, *AM J. Pharm. Educ.*, Vol. 44, No. 1, 16-24, (1980) as the outstanding article published in the 1980 edition of the *American Journal of Pharmaceutical Education*. It reported a study of the validity of using written simulations of close-to-real life situations as a means to measure pharmacy students' therapeutic problem solving ability.

The paper makes a significant contribution to the literature of pharmacy education on a subject that has a great impact on the ability of future pharmacists to practice appropriately. As stated by the authors, "Since problem solving ability is so central to effective pharmacy practice, the teaching of these decision-making skills should be an integral part of current pharmacy education. Moreover, pharmacy educators must have tools for effectively assessing the skills they purpose to teach."

At the University of Maryland, the authors' home institution, the Department of Clinical Pharmacy offers two required courses in which senior students are taught skills in problem solving, a therapeutics course and a four-week clinical clerkship experience. This was the setting used to test the effectiveness of written simulations. The utility of the written simulation approach to problem solving was measured against the more traditional approaches of multiple choice examinations based on case studies, small group problem solving sessions, and patient audits. Results of the study affirmed the value of the written simulation method, while noting the need for additional study in order to make better judgements about the psychometric acceptability of this method.

David Roffman was the principal developer of the University of Maryland Therapeutics Course and the problem solving teaching techniques it employs. Dianne Tobias had principal responsibility for developing the Written Simulations. Stuart Speedie developed the design and carried out the analyses for the validation experiment.

The Lyman Award is presented in honor of the contributions to pharmacy education of the late Dr. Rufus A. Lyman.

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TO ALL CONCERNED PERSONS:

The Maryland State Dental Association, aware that dentists may suffer from diseases involving alcohol and drug abuse or other impairments which might endanger their professional or personal well being, has created a special identification, treatment and rehabilitation program. The MSDA members working in this program will travel in teams of two to visit an identified and verified disabled dentist to persuade him or her to enter the treatment program prescribed. The program committee in turn assumes an advocacy and protective role with the local dental society, State Board of Dental Examiners, and drug enforcement agencies.

The committee views the abuse and addition to alcohol and other drugs as well as emotional and psychiatric disorder to be illnesses. These illnesses are treated non-judgementally, non-punitively and therapeutically. A variety of treatment plans are offered which are tailored to the individual's total needs in his work, family, finances and community. These varied treatment programs have proved to be highly successful and these diseases are treatable. People who suffer such disabilities are, due to the nature of the disease, usually unable to obtain aid on their own. Assisting them to treatment requires the efforts of concerned colleagues, family members or friends.

Inquiries to the program are strictly confidential and can be made by calling (301) 796-8441, between the hours of 9AM and 4PM, Monday through Friday.

Your assistance will be appreciated.

The Committee for the
Rehabilitation of Dentists

Dear Sir:

I am looking for a mild healing salve called Rose-Vel. No drugstore or pharmacy in the many that I have contacted can help me in any way. Only on druggist ever heard of it.

This product was distributed by a company in Riverdale, Maryland for several years. But this company has now gone out of business. I am not certain, but the Parker Co. sticks in my mind as this distributor.

Can you do anything to help me find out the manufacturer and/or another distributor?

Many sincere thanks,

Barbara C. Gannon
36 Church St.
Goffstown, NH 03045

Dear Dave:

It is interesting to observe how little of the discourse on the "P-D" issue concerns itself with the pharmacy consuming public, especially since it is they who represent the bottom line in any such inter-professional exercise. If consulted, I expect they would look upon the present furor with a jaded eye.

For generations it is they who have adopted, used, and been totally comfortable with the quasi-official "doctor" in identifying the pharmacist. It has been done with such spontaneity and frequency, pharmacists have despaired of denying the salutation.

Now and for the foreseeable future the community pharmacist dominates pharmacy's image. He is the one who must be understood as well as appreciated so that we can maximize the utilization of his knowledge and establish him as *THE* drug expert.

If P-D or anything else positively impacts or enhances that image, why not? With precedence clearing the way, there is nothing to overcome except pharmacy's inherent timidity.

With best wishes,

Bunky Lachman
Reisterstown, Maryland

EDITOR'S NOTE: *The M.Ph.A. adopted the designation "P.D." at its June Convention. Watch the August Issue for details.*

Dear Mr. Banta:

Throughout this past year, the Committee on Public Relations of the Pennsylvania Pharmaceutical Association has enjoyed and appreciated the professional courtesies extended by the Maryland Pharmaceutical Association.

Your staff was most helpful in providing our committee with a cassette taping of your "P.D. Debate". We also appreciated the courtesy of giving us permission to reprint the list of PMA Company Pharmacy Relations contacts developed by your Industry Relations Committee.

Enclosed you will find a check to defray your costs in sending the tape. We apologize for the delay in mailing the check.

The Committee on Public Relations is eager to continue this professional exchange between associations. If, at any time in the future, we can be of assistance, please feel free to contact us.

Respectfully,

James M. Kirkwood, R.Ph.
Andrea L. Pugh, R.Ph.
Co-Chairmen
Committee on Public Relations



David Banks (left), the new President of the University of Maryland School of Pharmacy Alumni Association, presents an award to Sanford Rosenbloom the outgoing President.



The Chancellor of the University Baltimore Campus, Albert Farmer, presented remarks to the Alumni Association Graduation Banquet held May 29, 1981 in Baltimore.



Mary-Terese Andres (left) received the Alumni Association's Frank J. Slama Award for extra-curricular activities from Mrs. Slama.



Charles Spiegelmire (left) presents an award to the Alumni Association's Honored Alumnus, Hyman Davidov.

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A Hidden Source of Working Capital*

Inflation and the high cost of borrowing continue to aggravate pharmacy operations. Runaway fuel and utility costs, significantly higher labor expenses, and continuously rising inventory costs have forced pharmacy cash levels to an all time low. Prevailing interest rates make borrowing almost prohibitive for those lucky enough to even have access to loans.

There is, however, a low-cost, internal source of working capital that most pharmacy managers overlook. A change in the way inventory is valued can improve a pharmacy's cash position dramatically. The change allows pharmacists to take the even higher cost of pharmacy inventory into account when defining taxable income. A lower taxable income means lower income taxes, thereby improving a pharmacy's cash position. Money saved in this way carries no heavy interest penalty and can be used to meet other expenses, reinvested to expand pharmacy operations, or withdrawn for personal use.

Pharmacy inventory must be counted and valued at least once annually to comply with state and federal laws. This physical count of inventory is necessary to develop the pharmacy's "cost of goods sold," which in turn helps define taxable income. And, that's where the valuation of inventory becomes critical!

A pharmacy's cost of goods sold is calculated by subtracting the value of all inventory left at the end of the accounting period (the "ending inventory") from the sum of (a) the value of inventory on hand at the start of the period (the "beginning inventory") and (b) all goods purchased during the interim. Any change that reduces the value of ending inventory necessarily increases the cost of goods sold on a dollar-for-dollar basis. An increase in the cost of goods sold reduces taxable income and therefore reduces the amount paid in income taxes.

An example will demonstrate the relationships most effectively. Figure 1 represents a simplified income statement for a mythical pharmacy.

ABC had \$70,000 of inventory (valued at cost) on hand at the beginning of 1980. During the year ABC purchased \$266,000 of goods and valued its ending inventory at \$76,000. Subtracting the cost of goods and all operating expenses left a net income of \$20,000.

Figure 1
ABC PHARMACY
Year Ending 12/31/81

Revenues.....	\$400,000
Opening inventory.....	\$ 70,000
Purchases.....	+ 266,000
Goods available.....	336,000
Ending inventory.....	- 76,000
Cost of goods sold.....	- 260,000
Gross margin.....	140,000
Expenses.....	- 120,000
Net Income.....	\$ 20,000

Assume, however, that the ending inventory figure was revalued to \$69,000. The change increases the cost of goods sold figure to \$267,000, while simultaneously reducing net income to \$13,000. Assuming a marginal federal income tax rate of 46% (which is not unreasonable for pharmacies), ABC would have paid \$3,220 less taxes on 1980 earnings by revaluing. There would be additional savings from state and local income taxes and from personal property/inventory taxes. Insurance coverage on the inventory could be maintained at the higher figure, so there will be no increase in risk.



*By Bruce R. Siecker, Ph.D., Director, APhA Pharmacy Management Institute, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.

In cases examined by the APhA Pharmacy Management Institute, overall savings have approximated \$4,500 annually by changing the way ending inventory is valued. So long as inflation continues a pharmacy could realize savings each year, even though the ending inventory for one year becomes the opening inventory for the next period.

The real question, of course, is how does \$76,000 legitimately become \$69,000? The answer requires an appreciation for two major approaches to valuing inventory and how pharmacy managers typically report inventory figures. The first method, known as "FIFO" for "first in, first out," assumes that inventory left at the end of the accounting cycle represents the most recently purchased stock. That is, the flow of inventory — from purchase to sale — occurs in sequence. The most recently purchased inventory valued under this assumption takes on the highest value possible.

A second assumption is that stock does not sell in the same sequence that it is purchased, that it moves through the pharmacy on a "last in, first out" basis (LIFO). This approach assumes the "dogs" stay on the shelf, while most sales are a result of the most recently purchased inventory. Under this assumption the ending inventory is valued at the costs evident at the beginning of the accounting cycle — prior to the inflation evident during the year. With LIFO inventory on hand at the end of the year takes on the lowest possible value.

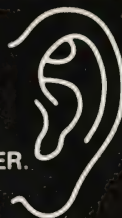
Most pharmacy managers count and value inventory using the FIFO method or the "retail" inventory method (for all non-prescription department inventory). Managers tell clerks to look up current costs in a suitable pricing guide or to reduce the selling price by a standard markup percentage. Both methods place a maximum value on ending inventory during an inflationary period!

By switching to a LIFO method a pharmacy can legitimately revalue its inventory to costs evident at the beginning of the period. Use of LIFO requires that a pharmacy submit Form 970 with its tax form and use LIFO valuation in financial reports to owners and in credit statements. LIFO may be used to value all or parts of a pharmacy's inventory, but must be continued once adopted unless the IRS permits a return to FIFO reporting.

To date, there are very few independent pharmacies using LIFO cost calculations. One reason seems to be lack of information. It is more likely, however, that managers who have investigated how the calculations have to be made have concluded that the tedium and cost are not worth the savings. That was true until inflation went crazy and the IRS amended its regulations. IRS now allows taxpayers to compute inventory price indexes for valuing inventory groups based upon 80% of the percentage change for the commodity group in the Consumer Price Index (CPI) or Product Price Index (PPI) published by the Bureau of Labor Statistics. Although the simpler method will result in more conservative savings, it is simple and inexpensive to do.

Inflation is not likely to disappear, so efforts directed at improving cash flow, productivity, or decreasing costs merit a manager's attention. A change to LIFO valuation of inventory is well worth thinking about as a means of improving the supply of working capital.

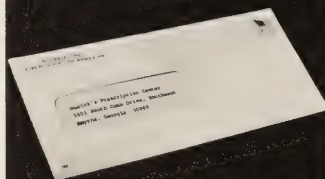
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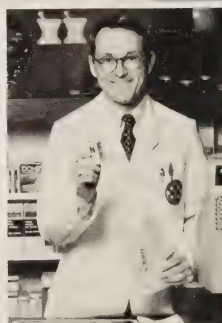
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School of Pharmacy Graduation

Pictures courtesy Abe Bloom
District-Paramount Photo



Pharmacy students Kathy Dunn (left) and Janet Weatherly (right) are shown with President Samuel Lichter shortly after receiving MPH A Scholarship Awards from him. Kathy received the Harry D. Kaufman Fellowship Award for her work in Community Service. Janet received the 1981 Scholarship Award honoring the memory of John Wanewetch.



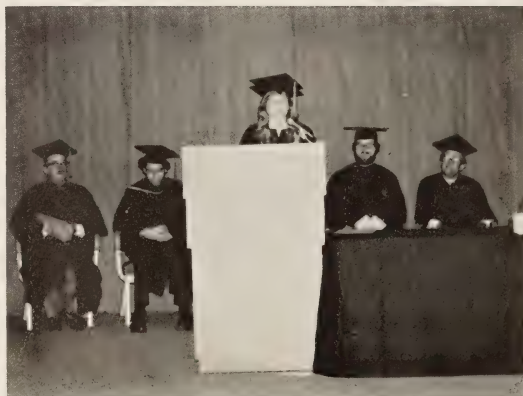
The School of Pharmacy's Honors Day Convocation was held May 29, 1981 at the Medical School Teaching Facility. The Graduating Class is shown just before the processional.



Relatives and friends of the graduating class watched while some 20 awards and prizes were presented.



Each Pharmacy graduate received the personal congratulations of Dean William J. Kinnard, Jr. (left).



Lucy Mellington, President of the Class of 1981 presented remarks on behalf of the class.

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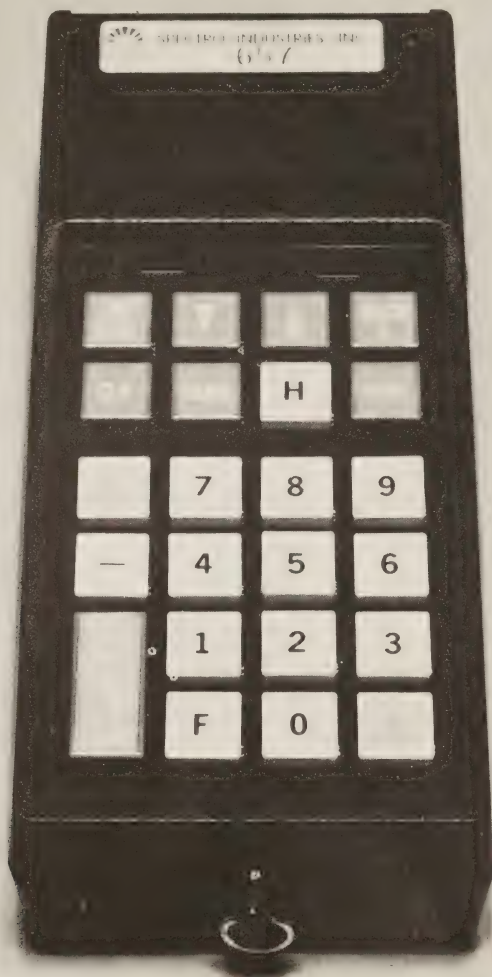
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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

SALINE IN SHOCK:

If shock persists for a long time, it may become refractory to therapy and lead to death. Twelve patients with this potentially fatal condition were given intravenous injections of 7.5% saline solution ranging in amounts from 100 ml to 400 ml. The effects of shock were reversed in eleven of these patients along with a rise in the arterial pressure, increased urinary flow, and a return to consciousness. The use of hypertonic solution reduced the requirement for isotonic fluids by 90 percent. *LANCET*, Vol. II, #8202, p. 1002, 1980.

OXAMNIQUINE:

Schistosomiasis is a disease that is produced by a parasite which infects the blood and hepatic tissue. The first drug approved by the FDA for use in treating this condition is oxamniquine (Vansel), a product marketed by Pfizer and Co. Oral administration of the drug acts to eradicate the parasite which is a common problem in areas of Latin America and Africa. An intermediate host, a certain type of snail, does not exist in this country and thus the disease is essentially unheard of in the U.S. However, millions of people throughout the world are infected by this organism and the use of oxamniquine is looked on as a way to bring relief to people suffering from an age old problem. *DRUG THER*, Vol. 10, #12, p. 31, 1980.

CAPTOPRIL:

Captopril is being used experimentally to help lower blood pressure by inhibiting the activation of angiotensin II, a potent vasoconstrictor. Clinical experience with this drug indicates that its effectiveness seems to be increased when it is used with a diuretic. The dosage of the drug will determine the frequency of administration since the duration of its antihypertensive effect is dependent on dosage. It has also been noted that the drug may lead to the development of hyperkalemia in patients with reduced renal activity. It must also be used with caution in patients taking potassium-sparing diuretics and in those who normally have high plasma potassium values. *JAM MED A*, Vol. 244, #22, p. 2532, 1980.

PROPRANOLOL:

A rise in serum potassium has been seen in patients receiving beta-adrenergic blocking drugs. In efforts to determine the cause of this phenomenon, two different beta-blocking agents were administered to volunteers. Propranolol, a drug which alters renin activity and plasma aldosterone concentrations, was given to one group while the other matched group received pindolol, a beta-adrenergic blocking agent which does not alter renin or aldosterone activity. Both groups showed an increase in serum potassium thus

suggesting that the increase in potassium is not dependent on alterations in either renin or aldosterone activity. In-vitro experiments show that propranolol will stimulate the release of potassium from human red cells and this may be one reason that patients taking beta-adrenergic blocking agents are prone to experience an increase in the plasma levels of potassium. *CLIN PHARM*, Vol. 28, #6, p. 765, 1980.

PSORIASIS:

It has been postulated that psoriasis may be at least partially due to the presence of genetic factors. Further information has supported this hypothesis. Investigators have found that in activity of an enzyme, aryl hydrocarbon hydroxylase, differs from normal activity in patients suffering from psoriasis. Since enzyme activity is under genetic control, there may be a connection between these disease and predisposing genetic conditions. *BR MED J*, Vol. 28, #6251, p. 1315, 1980.

SODIUM VALPROATE:

Sodium valproate (Depakene) is an anticonvulsant used to treat certain types of epileptic conditions. The drug can produce serious side effects including thrombocytopenia, alopecia, depletion of fibrinogen, and pancreatitis. The most severe side effect is acute liver disease which has resulted in death in 3 of 5 people included in this study. *LANCET*, Vol. II, #8204, p. 1110, 1980.

ADRIAMYCIN:

Adriamycin is an antibiotic extensively used as an antineoplastic agent. The drug consists of an amino sugar coupled through a glycosidic linkage to an anthracycline moiety. Since the molecule is of a class which is generally decomposed by light, an experiment was designed to determine if adriamycin solutions used clinically might be less potent than expected. Stability studies conducted with solutions containing various strengths of the drug indicate that photolytic degradation is likely to be significant only when the drug is in very dilute solutions. Concentrations of the agent used clinically did not seem to be adversely affected by light. *J PHARM PHA*, Vol. 32, #12, p. 860, 1980.

INTRAVENOUS SALICYLATES:

Lysine acetylsalicylic acid is a soluble salt of aspirin which has been used intravenously to help control post-operative pain. It compared favorably with morphine in a few patients and caused less nausea and vomiting than did the narcotic. It also fared well when compared to the effects produced by intravenous oxycodone. Initial studies have been conducted in only a few patients, thus more experimentation is expected before the preparation will be considered for wider use. *LANCET*, Vol. II, #8208, p. 1346, 1980.

SULFASALAZINE:

Ulcerative colitis is treated with sulfasalazine (Azulfidine). It has long been known that sulfasalazine is metabolized by colonic flora to form 5-aminosalicylic acid and sulfapyridine, but it was still uncertain as to which agent was responsible for the therapeutic effect. Patients with ulcerative colitis were given either sulfasalazine, 5-aminosalicylic acid, or sulfapyridine and their condition was monitored. The highest remission rate was obtained with 5-aminosalicylic acid (86%) followed by sulfasalazine itself (64%) and then sulfapyridine (14%). It has been suggested that 5-aminosalicylic acid be utilized as a single drug entity for treating ulcerative colitis. *N ENG J MED*, vol. 303, #26, p. 1499, 1980.

ASTHMA:

A few patients with severe asthma require steroid therapy to maintain adequate respiratory function. Many of these patients receive other therapeutic agents, e.g. theophylline, along with the steroids, but some clinicians have questioned the value of these more conventional agents when they are used in addition to the steroids. An experiment was designed to determine the value of these agents in 62 steroid-dependent asthmatics. Results indicate that the chronic use of theophylline is of value and produces a clear clinical benefit in patients with chronic steroid-dependent asthma. *N ENG J MED*, vol. 304, #2, p. 65, 1980.

AGE AND MORPHINE ANALGESIA:

A retrospective study was conducted with data obtained from cancer patients receiving intramuscular morphine to help allay pain. The duration of the analgesic effect was recorded along with the age of the patient. It appears that the analgesic effect of morphine is enhanced in elderly patients. Although a decrease in metabolism might help increase the duration of analgesia, it has been suggested that a greater fraction of the opiate derivative is available in the bloodstream as the unbound moiety and thus exerts a greater pharmacological effect at lower plasma levels. *CLIN PHARM*, vol. 28, #6, p. 823, 1980.

RHEUMATOID ARTHRITIS:

Patients with rheumatoid arthritis received intra-articular injections of either aspirin, hydrocortisone, or saline solution. All three preparations were found to be equally effective in relieving the pain associated with this condition. The authors of this article suggest that saline is effective because 51% of the people with rheumatoid arthritis respond to any type of placebo injection. This may be due to mechanical effects which are produced by removal or addition of fluid into the synovial sac. *LANCET*, vol. II, #8204, p. 1099, 1980.

PROCAINAMIDE:

Procainamide (Pronestyl) is metabolized to acetylprocainamide and excreted in the urine as either the parent compound or the metabolite. Approximately half of procainamide is excreted as the unchanged molecule, but the metabolite, n-acetylprocainamide, is also an active antiarrhythmic agent. It is important to evaluate renal function

in patients selected to receive this drug which is primarily removed from the body by renal excretion. Since renal function decreases with age, it is necessary that dosage adjustments be considered in elderly patients in order to prevent the development of toxicity. *CLIN PHARM*, Vol. 28, #6, p. 980, 1980.

LONG-TERM ESTROGEN THERAPY:

Many risks associated with long-term utilization of estrogenic substances have been found to exist. A recent study shows that some benefit with respect to reducing bone fractures may arise from this type of therapy. The risk of fracture was 50 to 60% lower in patients who have used the drug for at least a six-month period of time. The relative benefit/risk ratio must be carefully weighted before the drug is used. When used, frequent check-ups are required to prevent the development of side effects. *N ENG J MED*, Vol. 303, #21, p. 1195, 1980.

PHENOBARBITAL AND PITUITARY GONADOTROPINS:

Twenty boys being treated with phenobarbital to prevent febrile convulsions were examined to determine the effect of long-term phenobarbital therapy on the activity of prolactin and thyrotropin-releasing hormones. Therapy did not reduce the response produced by prolactin or thyrotropin releasing hormone, but it did reduce the activity of the growth hormone. The duration of these changes after discontinuation of therapy is not yet known. *BR MED J*, Vol. 281, #6249, p. 1175, 1980.

ALCOHOLIC CIRRHOSIS:

Chronic ethanol ingestion can lead to hepatotoxicity and death. In order to help the cirrhotic liver maintain more normal metabolic function, enzyme-inducing agents such as phenobarbital and medroxyprogesterone acetate were administered to 18 patients with chronic alcoholic cirrhosis. Liver function, especially with regard to drug metabolism, became closer to normal under the influence of these inducing agents. *CLIN PHARM*, Vol. 28, #5, p. 629, 1980.

OBESITY:

Obese patients were given anorexiant therapy, behavioral therapy, or a combination of both in order to determine which regimen would be more effective in promoting a permanent loss of body weight. Patients receiving the combination therapy lost the greatest amount of weight during the test period, but those given behavioral therapy alone lost almost as much. After one year, those who had received the behavioral therapy alone gained back far less weight than did those on other programs. The effectiveness of anorexiant therapy has been questioned for some time and this article tends to support the concept that weight loss due to anorexiant therapy is generally only temporary. *LANCET*, Vol. II, #8203, p. 1045, 1980.

DOSAGE REGIMENS:

Patient compliance generally increases as the number of doses required per day decreases. In order to determine the

relative effectiveness of combinations of clonidine and chlorthalidone (Combipres), fourteen patients received the medication in either single or divided doses. After a period of time, a cross-over was performed. There was no difference in the effectiveness of the regimens and those authors have concluded that Combipres can be used effectively if taken at bedtime in a single dose. *CLIN PHARM*, Vol. 28, #5, p. 581, 1980.

LEVAMISOLE IN MALIGNANT MELANOMA:

Levamisole is an anthelmintic agent which has been used to increase cell-mediated immunity in laboratory animals and humans. Malignant melanoma is a condition that is thought to be affected by the ability of the host to produce an immuno response, so a double-blind study was designed to compare the effects produced by levamisole with those produced by a placebo. The randomized, prospective study conducted in patients with malignant melanoma indicates that no significant difference occurred in patients receiving the anthelmintic, and thus its usefulness in this condition should be considered non-existent. *N ENG J MED*, Vol. 303, #20, p. 1143, 1980.

HEPATITIS B:

Hepatitis B virus has not yet been successfully grown in tissue culture, as such vaccines have to be prepared by diluting and heating serum of patients known to have the virus present. A new method has been utilized in which the plasma of the chronic carrier is treated with formalin to inactivate the viral particles. Initial studies with the new vaccine indicate it is effective if administered within 48 hours after exposure to the hepatitis B virus. *BR MED J*, Vol. 281, #6255, p. 1585, 1980.

DMSO:

Much interest has been generated recently by the suggestion that dimethylsulfoxide (DMSO) may be valuable in the treatment of arthritis. Two elderly patients who received the drug intravenously were found to experience a change in aspartate transaminase, hydroxybutyrate dehydrogenase, and creatine kinase along with clinical evidence of cellular hemolysis. The drug was discovered in 1866 and to date has only been approved by the FDA for treatment of cystitis. *LANCET*, Vol. II, #8202, p. 1004, 1980.

MYCOPLASMA ORGANISMS:

Mycoplasma organisms are generally thought to produce benign respiratory tract infections, but most often are not regarded as serious threats to life. Investigators have found that infections produced by this group of organisms may be more common than currently realized. Ureaplasma urealyticum (formerly called T-strain Mycoplasma) has been found to be the cause of non-gonococcal urethritis which can lead to infertility, spontaneous abortion, and stillbirth. Isolates of Mycoplasma organisms have been obtained from cultures taken from the respiratory tract, the urinary tract and the synovial fluid. *N ENG J MED*, Vol. 304, #2, p. 83, 1981.

DIET AND CORONARY HEART DISEASE:

Twenty years ago approximately 1900 men were evaluated with respect to their diet and serum cholesterol levels in addition to other parameters. The study has been repeated in these same men and statisticians feel that excessive cholesterol intake will definitely increase the incidence and severity of coronary heart disease. The study was conducted in employees of the Western Electric Company. *N ENG J MED*, Vol. 304, #2, p. 65, 1981

VERAPAMIL:

Verapamil is one of a group of agents which are being used experimentally to prevent symptoms of heart disease. These agents inhibit the inward movement of calcium ions during depolarization; thus interfering with the conduction of impulses in cardiac tissue. Verapamil was studied with respect to the amount of drug bound to plasma protein under various conditions and concentrations. Data indicate that the drug is 90% bound to plasma protein at all concentrations used clinically, including post-surgical and dialysis periods. Norverapamil is the major metabolite of verapamil and has approximately 20% of the activity that is associated with the parent compound. *CLIN PHARM*, Vol. 29, #1, p. 29, 1981.

PRAZOCIN SYNCOPE:

Occasionally the initial dose of prazosin (Minipres) can cause extreme hypotension and syncope. This may occur because prazosin is a selective post-synaptic alpha blocking agent and thus reduces adrenergic tone to both arterioles and veins. A reduction in cardiac preload and afterload occurs and this is further exaggerated by dilation of vessels in the splanchnic bed. Syncope is most likely to occur in patients already taking diuretics and beta-adrenergic blocking agents. Second-dose syncope is less commonly seen because the body initiates a compensatory vascular reflex to adjust arteriolar resistance. Syncope may be reduced in severity or eliminated if extra salt intake is allowed prior to prazosin therapy to allow for vascular fluid volume expansion. *AM FAM PHYS*, Vol. 23, #1, p. 59, 1981.

DIABETES MELLITUS:

Insulin-dependent diabetes mellitus is characterized by a marked decrease in the number of insulin-containing beta cells in the pancreas. Serum of these patients has been examined and it was noted that the serum contained an antibody which has been shown to react with the active beta cell. Presence of the antibody in the serum is in itself insufficient to cause the disease because of 25% of the relatives of diabetics have been found to have the antibody, but do not show signs of the disease. *N ENG J MED*, Vol. 303, #26, p. 1493, 1981.

COLOR-BLINDNESS:

A red tinted contact lens has been invented which is said to help patients who have red-green color-blindness. The lens is worn on the non-dominant eye, but may require extended use before its optimal effects become apparent. The product is called X-Chrom lens. *J AM MED A* Vol. 244, #21, p. 45, 1980.

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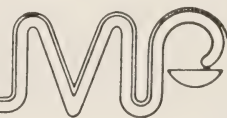
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PHYLLIS TRUMP — Baltimore



The MPhA House of Delegates overwhelmingly adopted the designation of "Pharmacy Doctor" (P.D.) at the June 1981 convention. Some pharmacists at the convention were using the designation in jest and making it the brunt of jokes. I hope they got that out of their systems. The Pharmacy Doctor designation is here to stay unless you, the profession, change it. Whether or not you agree with the designation, it is hard to argue that the previously agreed upon designation, "Registered pharmacist" (RPh) is more appropriate. Pharmacists are licensed, not registered. Registration is one of the lowest levels of state sanction; licensure is significantly higher.

On the other hand, the American Pharmaceutical Association continues to support the designation, "Pharmacist". Whichever designation you use, or do not use is your choice. Your professional performance is the important thing. The Pharmacy Doctor designation does connote a higher level of professionalism than some of us exhibit. We would all do ourselves a service if we would strive to be worthy of the designation. Let us hope that this will be the impetus for all of us to improve our practices, take our designation and responsibility more seriously and set an example for other professions.

Philip H. Logan

99th MPhA Convention

A Joint Successful Venture with Delaware Pharmacists

(Delivered by President Lichter at the
Annual Banquet)

It's over but not done with, my term as President. The continuity of the Association's activity becomes the responsibility of another to oversee. Professionally and personally my year has been one of transition and change. The Association has been active and involved in issues vital to the present and future of Pharmacy and Pharmacists.

The Maryland Pharmaceutical Association survives and persists, thanks to the efforts of many longstanding active members and its future depends upon the additional efforts of "born again" pharmacists and association members. My activity in the Association began during my career in hospital pharmacy with my fervent hope of developing a close working relationship between MPhA and MSHP. The mutual benefit of cooperative efforts is evidenced by the Tripartite Committee, the Continuing Education Coordinating Council, Legislative efforts, etc. This convention with our colleagues from Delaware will prove a pioneer effort can work.

The activity of the Association has for the most part been positive and successful. Maryland and its Pharmacists are repeatedly recognized on the state and national levels.

Thanks and much appreciation are herein expressed to Dave Banta, Paul Freiman, Dave Serpick, Mel Rubin, Ron Lub-

man, Bonnie Levin, Madeline Feinberg, Dean "Bill" Kinnard, Sharon Spies and Sandy (my wife) for enabling MPhA to progress during my term as President. Herein I also express my promise of continued effort towards the attainment of MPhA's and Phil Cogan's goals and objectives.

Thanks to the Industry Relations Committee for its efforts on behalf of Pharmacy, particularly relative to the problem of illegal drugs and their availability in Maryland.

Thanks to the Third Party Committee and all of the Ad Hoc members (grape vine) for the recent successful efforts on behalf of Baltimore City employees.

Pharmacy provided an outstanding joint venture at the first Consumer Awareness Expo. Many Marylanders participated in the White House Conference on Drug Abuse. The "Care First" HMO was made aware of the impracticality of establishing an in-house Pharmacy and eliminating the patient's freedom of choice.

Thanks to Stu Baltimore and Blue Cross/Blue Shield for the equitable relationship that continues to exist. Let us enlighten third party administrators and the employees in their groups to the benefits of adequate and just reimbursement.

Prepare to participate in the upcoming "Cost of filling a prescription" survey. Thanks need to be extended to the Maryland Association of Chain Drug Stores for recent cooperative efforts.

Thanks to Elwin Alpern for this 99th Annual Convention, to Frank Blatt and the membership Committee for an outstanding job, to SAPHa and its members for involvement during the past year.

Issues that need resolution will be addressed again during the MPhA 100th year: 1. P.D., 2. Supportive Personnel, 3. Pharmacy based HMO's, 4. Quality Assurance in Pharmacy Practice, and 5. Reimbursement for non-dispensing functions.

Thanks to one and all.



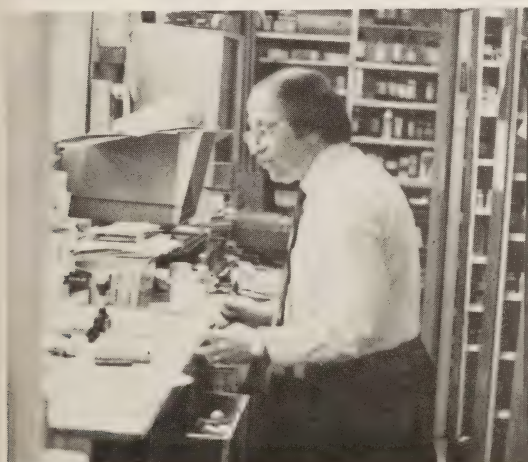
Samuel Lichter
President



Delaware Pharmaceutical Society President Keith Burechson helped to start the opening session of the Joint Convention. Delaware pharmacists participated in social and educational functions during the M.Ph.A. Convention.



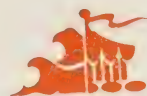
Maryland Pharmaceutical Association President Samuel Lichter presided over the 99th Annual Convention of the Association held June 21-25, 1981 in Ocean City, Maryland.



Sam Lichter is the owner of Block's Pharmacy in Baltimore and is shown at his busy prescription counter.

99th MPhA CONVENTION • 99th

MPhA Convention



at

the

Carousel

Ocean City, Maryland

MPhA CONVENTION

Pictures courtesy

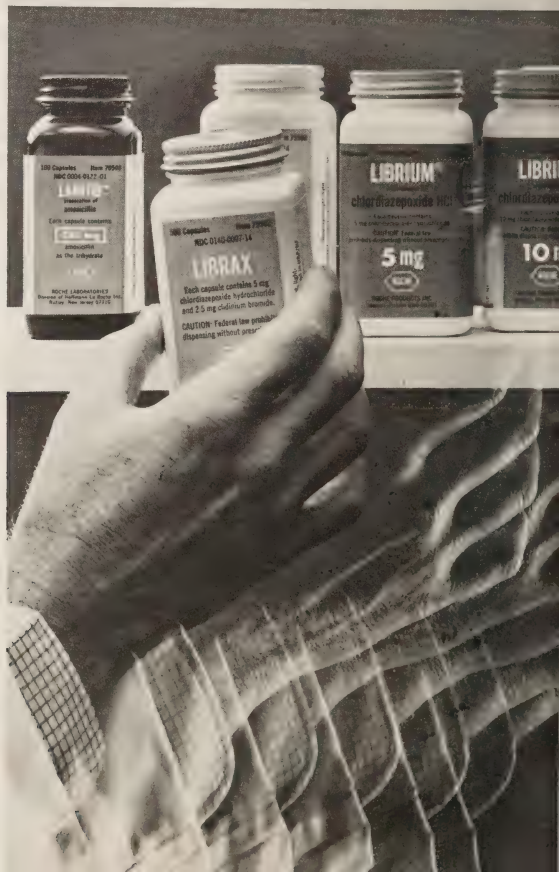
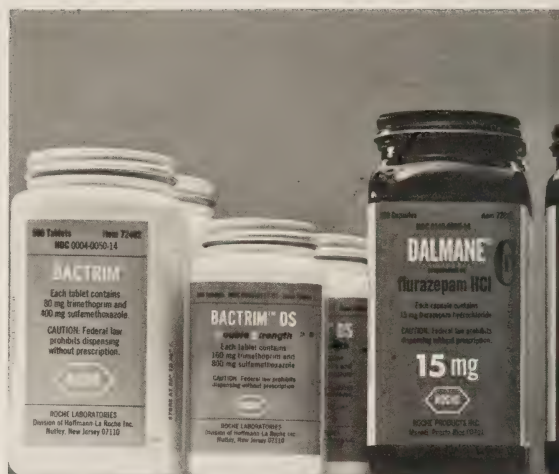
District-Paramount Photo

Philip Cogan was installed as President at the Convention and presided over the final session.



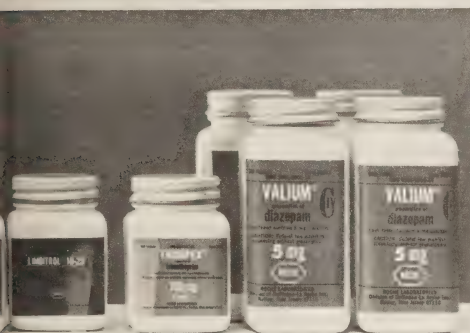
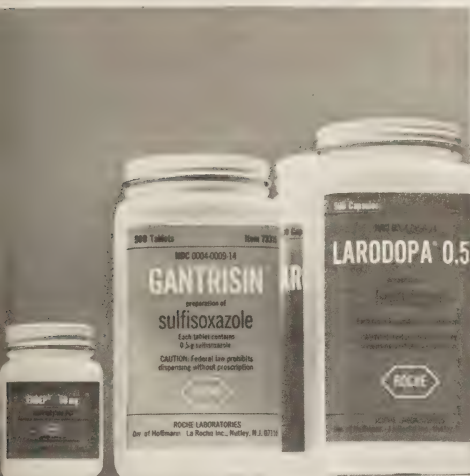
ROCHE. GOOD MEDICATION FOR BETTER PATIENT CARE,

Everything about Roche, from product research and manufacturing procedures to the representative who services your pharmacy, can be characterized by a single word—quality. Each time you dispense one of our products, you dispense the quality that lies behind the health care profession's wide acceptance of Roche. In fact, in a recent survey, Roche was the only company to achieve an "excellent" rating by pharmacy managers in all these significant areas: product quality, service effectiveness, and sales representation.¹



GOOD MEDICINE FOR BUSINESS TOO.

ROCHE



PHARMACY SURVEY CONFIRMS ROCHE RANKS HIGH IN 6 IMPORTANT ECONOMIC MEASUREMENTS

Roche performed best of 5 major pharmaceutical companies in an independent audit² encompassing these important parameters: sales revenue, total margin, gross margin, return on inventory, return on shelf space and inventory turnover. The implications are clear—given the opportunity, Roche products will perform well for you too.

Roche is millions of new Rx's ahead of the nearest competitor

A pharmaceutical monitoring organization has shown Roche to be the number 1 company in new prescriptions.³ This means faster turnover, which translates into increased overall business: Rx, OTC and front-end products.

Pharmacists select Roche Return Goods Policy as best in the industry

Pharmacists consider Roche to have the most liberal return goods policy in the industry. In an independent survey,⁴ Roche was rated first over the next ranking company by a margin of nearly 3 to 1. And our guaranteed return goods policy is synonymous with guaranteed sales for you, as well as better inventory control.

References:

1. *Chain Drug Review*, 1(23):6, July 30, 1979
2. Report prepared by Pracon Inc., Fairfax VA
3. Data on file, Hoffmann-La Roche Inc., Nutley NJ
4. *Pharmacy Times*, Inc., 1979 Report

Roche Rx's build traffic and traffic builds business

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

99th Convention

House passes "P.D." Designation and Record Number of Resolutions

RESOLUTION — NUMBER 1

BE IT RESOLVED, that the slate recommendations of the Nominating Committee for officers and trustees of the Association be approved by the House of Delegates of the MPhA at the Spring Regional meeting each year before election and Installation at the Annual Convention.

RESOLUTION — NUMBER 2

WHEREAS, the NAPLEX Pharmacy Board exam is now given nationwide on certain dates which are established well in advance, and

WHEREAS, the Board of Pharmacy is present during the examination period, and

WHEREAS, the MPhA has sought increased student membership and participation, and

WHEREAS, both the MPhA and students greatly benefit from mutual interactions at meetings,

THEREFORE BE IT RESOLVED, that the MPhA discourage the scheduling of conventions or other official functions during the NAPLEX exam or other student required activities.

RESOLUTION — NUMBER 3

WHEREAS, the APhA in 1973 adopted a resolution requesting those in attendance should not smoke in public meetings of the APhA, and

WHEREAS, the ASHP also adopted a non-smoking policy for their official functions, and

WHEREAS, the surgeon-general determined that smoking is hazardous to your health, and

WHEREAS, many people including many of our colleagues object to being subjected to the smoking of others,

THEREFORE, BE IT RESOLVED that MPhA forbid smoking at all official business functions.

RESOLUTION — NUMBER 4

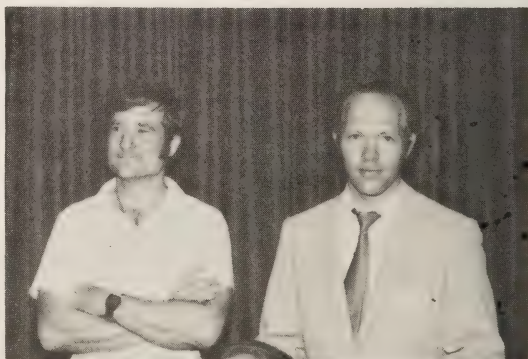
BE IT RESOLVED, that Maryland Pharmacists be discouraged from selling DMSO for unapproved uses pending FDA approval of it for medical indications,

BE IT FURTHER RESOLVED, that pharmacists become familiar with DMSO and be prepared to provide consumer information where appropriate on traditional forms of alternative therapy.

99th MPhA CONVENTION • 99th MPhA CONVENTION • 99th MPhA



The House of Delegates had an unusually productive session passing thirteen resolutions including one approving the designation "P.D." for pharmacists. (left to right) David Serpick, Speaker of the House; David Banta, Secretary of the House and Samuel Lichter, President.



Stanton Brown (left), President of the Prince Georges/Montgomery County Pharmaceutical Association and Lee Ahlstrom, President of the Anne Arundel County Pharmaceutical Association presented opposing points concerning the issue of professional designation.

RESOLUTION — NUMBER 5

BE IT RESOLVED, that the Maryland Poison Control Center and the pharmacies that participated, be congratulated for their work in promoting the 1981 Maryland Poison Prevention week effort

BE IT FURTHER RESOLVED, that all pharmacies be encouraged to participate in future Poison Prevention Week activities.

RESOLUTION — NUMBER 6

WHEREAS, it is the right and privilege of the Maryland Pharmaceutical Association to determine the professional designation of pharmacists, and

WHEREAS, the designation "Doctor of Pharmacy" abbreviated "P.D.", will modernize the pharmacist's designation and bring it in line with other health professionals on the "health care team", such as physicians, dentists, osteopaths, optometrists, and veterinarians, and

WHEREAS, the designation "Doctor of Pharmacy" is more descriptive of the practitioner of pharmacy considering the academic community's commitment to a universal doctoral entry degree, and

WHEREAS, the designation "Doctor of Pharmacy", abbreviated "P.D.", is more descriptive of the many expanding roles of the practice of pharmacy in the State of Maryland,

WHEREAS, practitioners of pharmacy, regardless of academic degree, have been addressed as "Doctor" in the State of Maryland for many years.

THEREFORE BE IT RESOLVED, the Maryland Pharmaceutical Association representing the pharmacists in the State of Maryland adopts the professional designation "Doctor of Pharmacy" with its resultant abbreviation "P.D.",

BE IT FURTHER RESOLVED, this designation will replace the previous designation "Registered Pharmacy", R.Ph., and shall be used in the same manner. It is not an academic degree, and it is not an endorsement for any particular pharmacy education degree.

RESOLUTION — NUMBER 7

WHEREAS, the current federal administration is proposing a number of budget reductions which may well have an adverse

effect upon the State Medical Assistance (Medicaid) Program, and

WHEREAS, The Maryland Pharmaceutical Association represents the entire spectrum of pharmacists who are vitally concerned that the delivery of quality pharmaceutical health care to needy recipients continue to be a high priority while, at the same time, pharmacists are fairly and equitably reimbursed for these services.

THEREFORE, BE IT RESOLVED, that the Maryland Pharmaceutical Association work with the state and federal governments to obtain equitable solutions to these financial and budget difficulties so that the least amount of harm will befall both recipient and provider.

RESOLUTION — NUMBER 8

WHEREAS, Elmer Sterling has made many notable contributions to the profession of Pharmacy, on the Eastern Shore region and,

WHEREAS, he has served as past president of the MPhA and until his death has been the oldest past president of the Association,

BE IT RESOLVED, that this Association recognize the contributions of Mr. Elmer Sterling in the form of a letter to the surviving widow and family of Mr. Sterling.

RESOLUTION — NUMBER 9

WHEREAS, there is significant interest within the pharmacist community in availability of graduate degrees to be obtained in a home study and/or part-time classroom setting, and

WHEREAS, there would be a benefit to practicing pharmacists who could not financially function as a full time student,

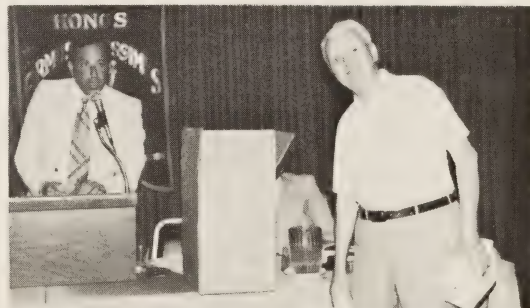
THEREFORE BE IT RESOLVED, that the Association support the establishment of such a program and,

BE IT FURTHER RESOLVED that an ad hoc committee be appointed to explore such a program with the University of Maryland, School of Pharmacy or any other accredited school of pharmacy would support such a program.

99th MPhA CONVENTION • 99th MPhA CONVENTION • 99th MPhA



Samuel Lichter (left) and Donald Fedder, the Official Parliamentarian for the House, count ballots during the extremely close election for Vice Speaker.



No M.Ph.A. Convention would be complete without Charles Spigelmire (right) handing out "early bird" (etc.) prizes at the start of each meeting. Dave Serpick (left) calls out the numbers.

Pictures Courtesy
District Paramount Photo

RESOLUTION — NUMBER 10

WHEREAS, Mr. Joseph Cahill, Manager of Radio Stations W.C.A.O. and W.X.Y.V. in Baltimore, Maryland, has been most kind, generous and cooperative with the Maryland Pharmaceutical Association the past year, in granting the Association fifteen minutes each week to present "Your Best Neighbor" radio program during the past year,

WHEREAS, the Officers, Delegates and guests of the Maryland Pharmaceutical Association are deeply thankful, for the warm consideration extended to them,

THEREFORE, BE IT RESOLVED, that the Officers and Delegates of the Maryland Pharmaceutical Association extend their deep appreciation and thanks to Mr. Joseph Cahill by presenting him with a suitable plaque for his cooperation and assistance.

RESOLUTION — NUMBER 11

WHEREAS, a prescription drug is not a commodity that can be sold by the efforts of pharmacists, and

WHEREAS, pharmacists stock these drugs on good faith that the manufacturers will detail them, and

WHEREAS, the pharmacist loses money and the manufacturer obtains the indirect use of high interest money,

BE IT RESOLVED that prescription drug manufacturers be informed that Maryland Pharmacists are dissatisfied with prescription manufacturers that set a time limit and/or decrease of credit on returns of such prescription drugs.

RESOLUTION — NUMBER 12

BE IT RESOLVED, that the Association recognizes the award-

ing of Alpha Zeta Omega Pharmaceutical Fraternity "Meritorious Award" to member Irving Goldberg.

RESOLUTION — NUMBER 13

WHEREAS, the Maryland Pharmaceutical Association and the Maryland Society of Hospital Pharmacists are committed to many of the same goals, and

WHEREAS, the Maryland Pharmaceutical Association and the Maryland Society of Hospital Pharmacists have entered into a renewed spirit of cooperation, particularly in the past several years, and

WHEREAS, the Annual Convention of the Maryland Pharmaceutical Association and the Annual Seminar of the Maryland Society of Hospital Pharmacists have in recent years often been held in close conjunction with regards to time and location, and

WHEREAS, there are continuing educational programs now held at these two meetings that would be of benefit and interest to both groups,

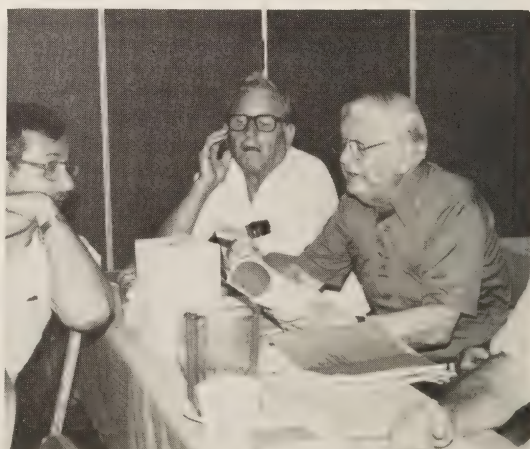
WHEREAS, such programs now involve duplication of effort with regard to sponsorship, speaker and other arrangements, THEREFORE, BE IT RESOLVED, that the Maryland Pharmaceutical Association approve the concept of instituting along with the Maryland Society of Hospital Pharmacists, one or more joint continuing education programs at the next earliest convention site where this would be feasible, and

BE IT FURTHER RESOLVED, that the Executive Director of the Maryland Pharmaceutical Association seek to establish liaison with the Maryland Society of Hospital Pharmacists in this regard.

• 99th MPhA CONVENTION • 99th MPhA CONVENTION •



Once again there was a large student turn-out for the Convention, not counting the fifth-year class which was busy taking the Board of Pharmacy Examination.



Victor Morgenroth (center of Picture), Chairman of the Constitution and Bylaws Committee, makes a point about procedure during the business session.

Perspectives in Pharmacy

Capitation*— Reimbursement for Pharmacy Services

Presented
in the interest of
better-informed
pharmacy.

*Capitation is a system of payment by which a provider receives a fixed amount for services rendered each person for a given time period, usually a month.

Jean Paul Gagnon, R.Ph., Ph.D.
Professor, Pharmacy Administration
School of Pharmacy
University of North Carolina at Chapel Hill

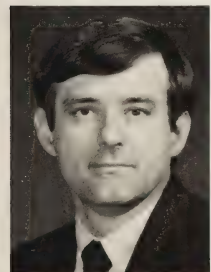
"Capitation is not new to pharmacy. As early as 1969, this system of payment was being discussed as a reimbursement method for pharmacy services.

"There are theoretical advantages to pharmacists being paid a fixed monthly rate per patient:

- service and administrative costs could be lowered;
- pharmacists would be able to consider patient needs first;
- pharmacists could keep abreast of current drug therapies and technology;
- greater continuity of patient care could be provided;
- utilization of high-cost services could be lowered;
- more extensive preventive health efforts could be made;
- and more favorable health outcomes might result.

"On the other hand, capitation may stimulate providers to:

- devote fewer hours to patient care;



Jean Paul Gagnon, R.Ph., Ph.D.

- refer patients to other facilities more readily;
- be more inflexible and less responsive in dealing with patients;
- screen potential enrollees for health status;
- place profit before services;
- and delay or prolong services.

"There is little documentation to support either the advantages or the disadvantages of capitation to the pharmacy profession. Because its use so far has been limited, capitation needs additional evaluation before a decision concerning its utilization can be made.

"In the long run, after pharmacists have realized 'windfall profits' through implementation of such cost-saving strategies as generic substitution and use of OTC drugs, capitation may be attended by the same problems as the fixed-fee

method. It is likely that, in times of tight money, legislators and program administrators would exhibit the same attitudes about capitation as they currently do toward fixed professional fees—they will be tempted to minimize costs by not raising the capitation rate. In fact, because of 'windfall profits' that will be generated in the early years of the capitation approach, state legislators will probably tend to reduce the rate. At the very least, pharmacists will be asked by legislators to justify rate increases by conducting cost studies of their operations.

"There is as much controversy today about third-party reimbursement for pharmacy services as there was in 1968. Because of federal antitrust laws and the lack of consensus on the part of pharmacists, pharmacy organizations have been unable to convince program administrators of the value of their services and the advantages of competitively determined prices as opposed to a cost-plus approach. In the final analysis, the capitation approach may serve only to delay solution of the reimbursement problem."

Raymond A. Gosselin, R.Ph., Sc.D.
President, Massachusetts College of Pharmacy
and Allied Health Sciences

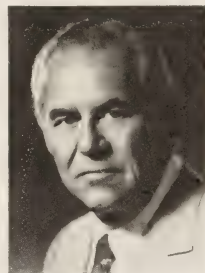
"Subjective appraisals of the capitation system are apt to be inconclusive in the short term, because, initially, there would seem to be some advantages, e.g., money up front, no claim forms, etc. But, at some point, pharmacists will have exhausted all opportunities to hold down costs by substituting less expensive drugs, eliminating refills, curtailing overuse, and switching patients to home remedies. Meanwhile, increasing amounts for rent, light, heat, taxes, and the like will have to be paid.

"Program administrators, faced with the need to eliminate the 'fat' from budgets and aware that pharmacists retain any amount left from the initial capitation fee that is not spent on program recipients, would inevitably cut successive annual funding.

"The bottom line of any proposed capitation system would not be in savings realized by curtailing overuse or by switching patients from prescription drugs to over-the-counter ones but in using less expensive generic drugs. The capitation system, in effect, would be no more than a mechanism for forcing the use of the cheapest drugs available. Making a choice based on price as the sole criterion does not involve professional judgment. Under a capitation system, pharmacists would have to resort to the lowest-priced drugs in order to remain in business.

"As long as pharmacy remains a predominantly private enterprise in this country, and there is little to indicate otherwise, incentives for providing new and better services—including patient consultation and monitoring—need to be positive rather than negative. New activities for pharmacists must be justified in terms of building clientele, increasing volume and business, and earning a reasonable profit.

"Pharmacists can play a major cost-saving role in health care by helping people get well and stay well by means of the proper application of efficacious drug therapy. Billions can be saved in physicians' fees, hospitalization costs, diagnostic tests, and the like by aggressive and positive application of pharmacists' skills. Such expertise is valuable, and pharmacists should be paid for their contribution. The cost of such services is indeed small in relation to the genuine savings in total health care that can be realized."



Raymond A. Gosselin, R.Ph., Sc.D.



Eli Lilly and Company
Indianapolis, Indiana 46285

The views expressed are the authors' and not necessarily those of Eli Lilly and Company.

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ANNUAL REPORT OF THE MARYLAND BOARD OF PHARMACY 1980-1981

In compliance with the provisions as set forth in Section 285 of Article 43 of the Annotated Code of Maryland, this report is submitted to the Honorable Harry Hughes, Governor of Maryland and to the Maryland Pharmaceutical Association. This is the seventy-eighth report to the Governor and the sixty-eighth report to the Association. The report covers the activities of the Maryland Board of Pharmacy for the fiscal year ending June 30, 1981. This report is also being submitted to the Secretary of Health and Mental Hygiene, the McKeldin Library of the University of Maryland, the Enoch Pratt Free Library, the Department of Legislative Reference, the Hall of Records, and the State Library.

MEETINGS

During the year the Board held nineteen meetings, seven of which were held at the School of Pharmacy of the University of Maryland, for the purpose of conducting examinations for registration of pharmacists.

OFFICERS

Bernard Lachman was elected President and Paul Freiman was elected Secretary-Treasurer of the Board.

PERSONNEL

Roslyn Miller is the Administrator, Maureen D'Amico is the Steno-Clerk III and Margaret Lloyd is the Office Assistant II.

EXAMINATION

The Board conducted examinations for registration of pharmacists during the fiscal year. They were held at the School of Pharmacy of the University of Maryland on June 24, 25, 26 and 27, 1980 and January 27, 28, and 29, 1981.

The applicants who were examined in June of 1980 were licensed in July 1980 which is in F.Y. 1981. There were one hundred and seventy-three applicants for the Board in June, 1980. One hundred sixty-three passed both the theoretical and practical portions of the examination and were subsequently registered. Nine failed the examination. Having previously passed the theoretical portion of the examination, one candidate took the practical examination in June. The candidate passed and was subsequently registered.

There were nineteen applicants for the Board in January, 1981 (F.Y. 81). Eight passed both the theoretical and practical portions of the examination and were subsequently registered. Ten failed the examination. Having previously passed portions of the examination, one candidate took the practical examination in September. The candidate passed and was subsequently registered.

Data relative to the June 1981 examination will be given in the next Annual Report.

The Standard Examination of the National Association of

Boards of Pharmacy was given, which consisted of the following subjects:

- Chemistry
- Pharmacy
- Mathematics
- Pharmacology
- Practice of Pharmacy
- Laboratory
- Jurisprudence

The Jurisprudence examination included the Federal Law Exam on the Maryland Law Exam. The Maryland Law Exam was compiled by a member of the board and was given as a part of the practical portion of the examination, as well as the compounding of three prescriptions per applicant. The following table shows the number of pharmacists who were registered by examination during the past ten years:

YEAR	NUMBER OF PHARMACISTS
1971-1972	133
1972-1973	96
1973-1974	111
1974-1975	113
1975-1976	109
1976-1977	166
1977-1978	150
1978-1979	137
1979-1980	180
1980-1981	183

As in the past, many pharmacists applied for reciprocal registration in Maryland in order to accept positions with their employers who are opening stores in Maryland. Those applicants who did not meet our requirements concerning practical experience prior to or after registration in another state were advised that they must take our practical examination in order to verify their qualifications.

In all cases an applicant for reciprocal registration must appear for a personal interview. The entire Board must act on whether or not to grant registration to such applicants, who must sign an agreement to comply with Maryland's laws pertaining to drugs and pharmacy.

The following table shows the number of pharmacists granted registration by reciprocity and the number who were certified to register by reciprocity in other states during the past ten years.

Fiscal Year	Reciprocity	Certification
1971-1972	67	35
1972-1973	94	57
1973-1974	88	63
1974-1975	76	45
1975-1976	89	44
1976-1977	78	68
1977-1978	91	77
1978-1979	113	42
1979-1980	73	69
1980-1981	88	72
Total	857	572

The table shows Maryland gained 285 pharmacists by reciprocity during the past ten years.

New permits to operate a pharmacy were issued to 30 firms for the 1981 Fiscal Year.

Anne Arundel	2
Baltimore	8
Carroll	1
Charles	1
Garrett	1
Harford	1
Kent	1
Montgomery	4
Prince Georges	5
County Totals	23
Baltimore City	7
State-Wide Totals	30

MANUFACTURERS PERMITS

New permits to manufacture drugs, medicines, toilet articles, dentifrices, or cosmetics during 1980 were issued to three firms.

DANGEROUS DRUG DISTRIBUTORS PERMITS

The Board issued six new permits to sell, distribute, give or in any way dispose of dangerous drugs during 1981.

LEGISLATION

The following legislation which effects the profession of pharmacy either directly or indirectly was enacted by the 1981 Maryland General Assembly.

List of Bills that were enacted during the 1981 Legislative Session and their purpose as it pertains to pharmacy.

Bill No.	Short Title	Purpose
HB 1	Health Occupations Article	To revise and update pharmacy practices act.
HB 76	Drug Formulary	To delete some obsolete language regarding a positive formulary under the Medicaid program.
HB 132	Boards of Chiropractors, Electrology, and Pharmacy-Disciplinary Action	To allow the Board of Pharmacy to collect disciplinary fines.
HB 622	Drugs — Delivery of Non-Controlled Substances	To prohibit the delivery, attempted delivery, and possession with intent to deliver of noncontrolled substances intended for use or delivery as a controlled dangerous substance.
HB 1215	Maryland Medical Assistance Program Maryland Pharmacy Assistance Program	To repeal certain sections of the Annotated Code relating to the reimbursement of certain providers by the Maryland Pharmacy Assistance Program and the Maryland Medical Assistance Program for certain items that are currently determined to be ineffective by the United States Food and Drug Administration.
HB 1712	Public Ethics Law — Generally	To provide an exemption from the financial disclosure requirements of the ethics law for certain individuals including the faculty members of the school and the commissioners of the Board of Pharmacy.
SB 278	Medicaid — Pharmacy Assistance Program — Financial Eligibility	To alter the allowable income levels for determining financial eligibility for the pharmacy assistance program under the Maryland Medical Assistance Program.

DISCIPLINARY ACTIVITIES

The Board of Pharmacy receives complaints from the public concerning problems with the Board's licenses. For the period of July 1, 1980 to April 29, 1981, 63 complaints were received. There was a wide range of complaints which varied in severity. Listed below are statistics concerning the types of consumer complaints.

incorrect drug dispensed	16
communication problem	10
labeling error	8
dispute arising out of	
medical assistance cards	9
short count of pills	4
generic drugs	3
prices	2
complimentary drugs	2
look alike pill advertisements	1
excessive refills	1
unsanitary pharmacy	1
non-descriptive	4

Other complaints were received from the Division of Drug Control, Medical Assistance Compliance Administration, and the State of Maryland Courts. Four formal disciplinary hearings were held. Two pharmacists licenses were suspended. Two pharmacists licenses were revoked; both revocations were immediately stayed and the individuals placed on probation under certain conditions.

COOPERATIVE ACTIVITIES

The Board maintained membership in the National Association of Boards of Pharmacy. The annual meeting of the Association was held in Las Vegas, Nevada on May 3-May 7, 1981.

The Board was represented by Mr. Leonard J. DeMino and Mr. Robert E. Snyder.

The Board also maintained membership in the Conference of Boards and Colleges of Pharmacy of the National Association of Boards of Pharmacy, District Number Two, comprised of the states of New York, New Jersey, Pennsylvania, Delaware, Maryland, the District of Columbia, Virginia and West Virginia.

The Board maintained cooperative activities with the State Department of Health and Mental Hygiene, the School of Pharmacy — University of Maryland, the Maryland Pharmaceutical Association, the Federal Drug Administration, the Food and Drug Administration, City, County, and State Police and all Boards and Pharmacy Schools throughout the country.

FINANCES

All funds of the Board of Pharmacy are deposited to the credit of the Treasurer of the State of Maryland and disbursements covering the expenses of the Board are paid by voucher by the State Comptroller.

FINANCIAL STATEMENT

The Board of Pharmacy had revenues of \$95,404 in 1979 and \$31,102 in 1980. The Board of Pharmacy had expenditures of \$43,628 in 1979 and \$52,020 in 1980. The Board's budget is \$51,306 for 1981 and \$53,720 for 1982.

OTHER ACTIVITIES

In addition to the President Bernard Lachman and Secretary Paul Freiman, the Board consists of the following commissioners: Ralph Quarles, Robert Snyder, Leonard DeMino, Anthony Padussis, Estelle Cohen, and Phyllis Trump. All the Commissioners are registered pharmacists in the State of Maryland with the exception of Ms. Cohen and Ms. Trump who are consumer (public) members of the Board.

In 1980, the Board of Pharmacy began publishing with the cooperation of the National Association of Boards of Pharmacy a newsletter on a quarterly basis. This publication is distributed to all licensees and contains information on new regulations, laws, concerns of the Board, and an opportunity for pharmacists to state their concerns to the Board. The newsletter also contains news of national interest and concern to Maryland Pharmacists.

In 1981 the Board promulgated the following regulations: Price Poster — These regulations govern the manner in which the prescription price poster is to be completed and displayed. Initialing of a prescription — These regulations require identification of the pharmacist who compounded the prescription. Reciprocity Fees — Reciprocity in the State of Maryland will increase to \$100 as of July 1, 1981 for each licensee. Security of a Pharmacy — These regulations will assure security of a pharmacy. The Board is also at this time proposing Standards of Pharmacy Practice — These regulations will prevent the pharmacist from returning to his drug stock any prescribed drugs except certain unit doses, which have been previously sold and left in his possession. Also proposed are institutional pharmacy regulations.

In 1981, the Board continued its excellent relations with the Department of Health and Mental Hygiene. The cooperation and courtesy extended to the Board of Pharmacy by all members of the Department is appreciated by all the Board members. This year saw the transfer of the Division of Drug Control from the Environmental Health Administration to Regulatory Services. This change which the Board championed for many years, should lead to more effective control of drug distribution in Maryland. This is another example of the degree of coopera-

tion that the Board of Pharmacy has experienced in its relationship with Dr. Buck and the Department of Health and Mental Hygiene.

Again the Board must commend our administrator, Roslyn Miller for her continued excellent management of the Board's daily business. Through her efforts the Board continues to operate smoothly and efficiently. In addition, the Secretary must commend both of our excellent secretaries Maureen D'Amico and Margaret Lloyd for their excellent work and cooperation.

In addition to the items as stated, the Board participated in many activities too numerous to mention. All of the Commissioners actively participated by serving on various committees appointed by the President, attending numerous meetings throughout the State, and being available for consultations and special meetings when necessary.

Respectfully submitted,

Paul Freiman
Secretary-Treasurer

Membership Committee Reports New Gains

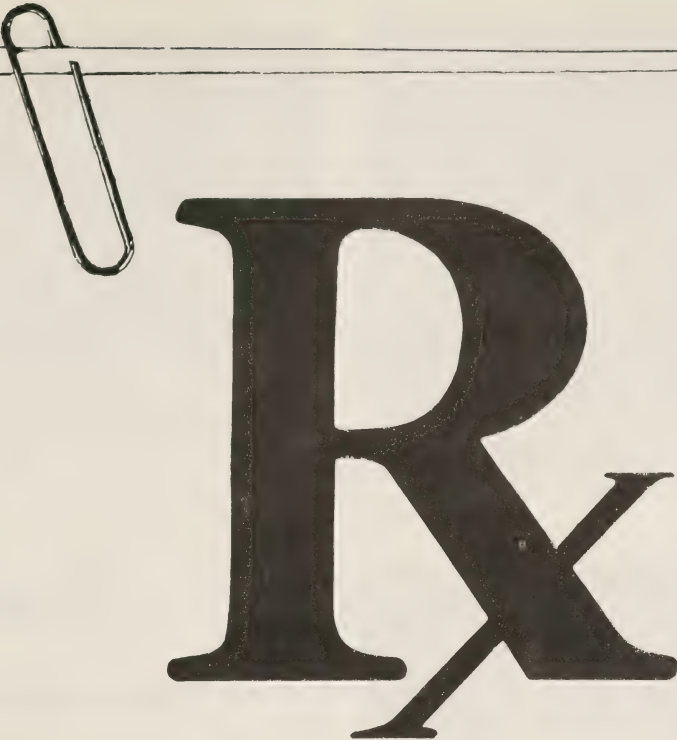
	AS OF 12/31/80	AS OF 6/20/81
TOTAL MEMBERS TO DATE	857	859
NEW MEMBERS TO DATE	92	67

COMPARISON:	
MEMBERS TO DATE	+ 2
NEW MEMBERS TO DATE	-25

BREAKDOWN:	12/31/80	6/20/81	comparison
Owner-Manager	212	209	-3
Non-owner	327	330	+ 1
Pledge — 1st year	78	62	-16
2nd year	39	49	+ 10
Hospital	37	34	-3
Graduate	8	8	0
Retired	63	72	+ 9
Non-resident	47	48	+ 1
Joint	3	6	+ 3
Associate	41	41	0
	857	859	+ 2
	2 comp	2 comp	
	859	861	

I would like to extend my fullest appreciation to the membership committee for their time and efforts this year. The statistics show that we are prospering even in a period of economic strife. I would also like to invite new volunteers to be a part of this committee. A few hours a year spent in any committee work really gives one a sense of great accomplishment.

Frank Blatt
Chairman



R

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and comics, and come back to see us
again in a few days."*

That's the prescription you can fill again and again for your customers if you have a fully stocked magazine department.

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Incoming President Philip Cogan (left) accepts the NARD Leadership Award from William Hill (right), an M.Ph.A. Board of Trustees Member representing the NARD at the Banquet.



Samuel Lichter (left) is presented with the E.R. Squibb Past President's Award by Jack Peters representing the Company.



Sandy Lichter (left) likes the Pharmacists Mate Award presented to her by William Brown of the Gelgy Company.

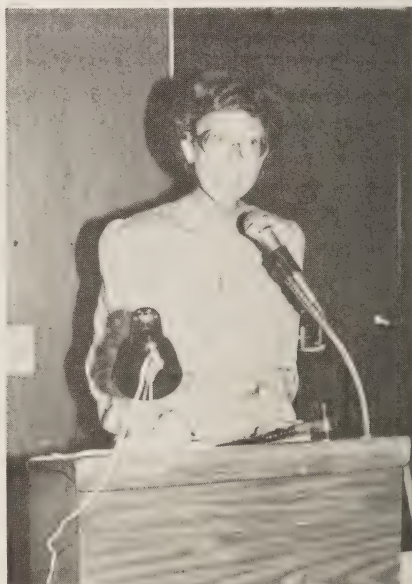


M.Ph.A. Officers and Trustees are shown shortly after installation during the business session. They are (left to right) Jim Terborg, Madeline Feinberg, William Hill, Charles Spigelmire (installing officer), Melvin Rubin, David Banta, Irvin Kamenetz, Philip Cogan, Samuel Lichter, George Voxakis, Ronald Sanford and Vincent Regimenti.

The 99th

● 99th MPhA CONVENTION

Pictures courtesy of Abe Bloom and District Paramount Photo



Madeline Feinberg, incoming Speaker of the House, served again as Toastmaster for the 99th Annual Banquet held June 24, 1981.



and Best

9th MPhA CONVENTION •



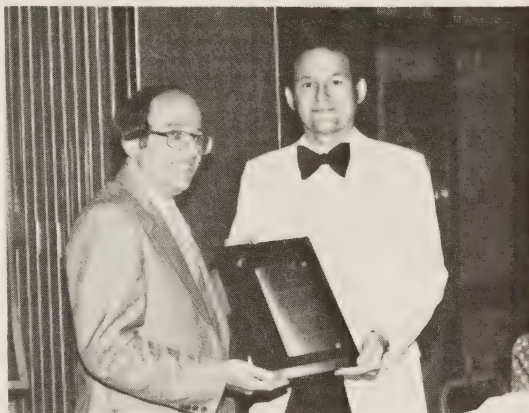
David Serpick (left), outgoing Speaker of the House, is recognized for his work during the past year with the Award presented to him by Charles Spigelmire (right), the Banquet Grand Marshal.



Melvin Rubin (right), receives the M.PhA Distinguished Achievement Award from Samuel Lichter (left). The award is presented for outstanding contributions to the Profession of Pharmacy.



Both Philip Cogan (left) and Samuel Lichter (center) accepted for the Association the Award of the American Institute of History in Pharmacy in recognition of the work to preserve the Kelly Memorial Building and Cole Museum presented to them by Stephen J. Provenza representing the Institute.

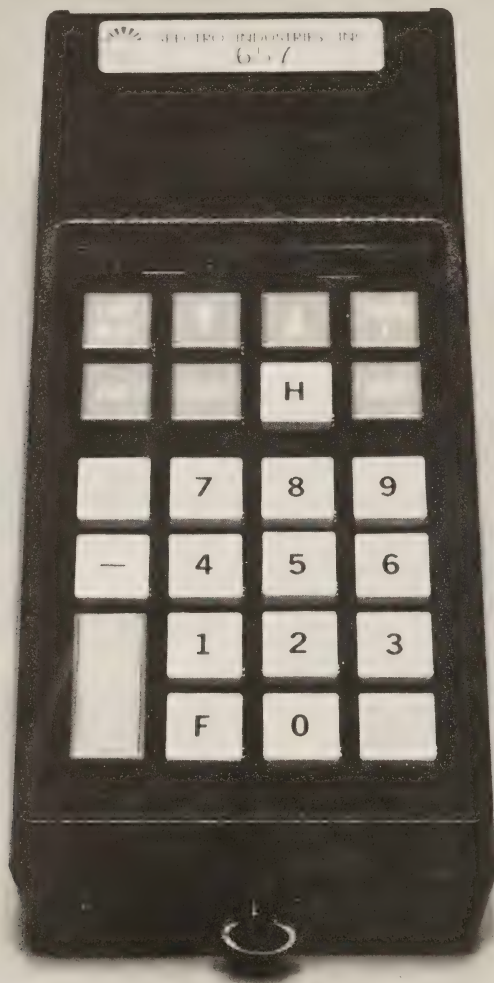


As the first act of his new office, Philip Cogan (right) presents Samuel Lichter (left) with the MPhA Past President's Award.



James L. Gundling (left) of Crisfield, Maryland received the A.H. Robins Bowl of Hygeia Award from Herbert W. Wendler (right). The award is presented for Jim's work in community and civic affairs.

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within 60 days, you don't
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Charles Spigelmire Honored



Charles Spigelmire (right) received a surprise award and plaque from President Samuel Lichter (left) in recognition of his long years of service to his profession in the area of public relations.



Spigelmire has produced a weekly radio talk show on Pharmacy called "Your Best Neighbor" for the past 23 years without ever missing a program. The show is the longest continuously broadcast public service program in the State. He has also served as Chairman of the Public Relations Committee.



Shown here before the studios of Radio Station WCAO and WXYV which broadcasts his weekly show, Spigelmire has indicated that he will retire from the regular broadcasts. The M.Ph.A. is now reluctantly searching for a pharmacist who will continue this great tradition of providing information to the public on pharmacy and related topics.



Spigelmire (right) chats with one of the studio engineers at the radio station who help record the broadcasts he has prepared. Each week Spigelmire discusses a new subject for his listening audience.

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Public Relations Committee

“Going Strong”

by

Charles Spigelmire

Chairman

Mr. Chairman, members of the Maryland Pharmaceutical Association, honored guests. Each day brings new ideas, unusual experiences, or a difficult challenge to pharmacy and the community pharmacist. The diversified nature and seriousness of any of these, demand that the pharmacists do his best to face and solve these problems as they arrive, in this highly competitive era, if he is to survive.

As a Pharmacist we have professional standing. A Pharmacist, in fact, holds a unique position. He is a friend and counselor or the neighborhood. He is sought out by his customers, for advice, and enjoys their confidence to a degree not known in any other retail business. This is a tremendous competitive advantage. The way to capitalize on it is to be properly informed, and to pass on that information in personal service. The combination of product knowledge and personalized service is our most useful competitive weapon.

During the past year your public relations committee has made a very dynamic and aggressive effort to let the public know and understand that Pharmacy is one of the oldest and most respected professions in existence today. Our messages about the community Pharmacist were informative, enlightening and widespread, because your committee believed implicitly that, "Those who have never heard of you, you do not exist".

You committee was fully convinced, that the factor which distinguishes the Pharmacist from other retailers is, that he is qualified to know all about the goods he supplies, and when necessary, to give advice about them. Any tendency towards self service in these goods is to deny the Pharmacist's special role in those lines which call merely for the most efficient selling methods. We should not be afraid to learn from any new developments in marketing without copying them slavishly. But in the supply of pharmaceutical lines proper, our strongest asset is the personal touch.

Your public relations committee realized full well that there have been tremendous inroads made in our business and patronage during the past years, without stern retaliatory publicity measures being taken.

It must be remembered that we felt the best results could be obtained for the community pharmacist by trying to fight competition, by publicity emanating from a city or state level. As you well know, your publicity committee leaves no stone unturned in making a sincere effort to obtain the maximum publicity our association and you the community pharmacist so justly deserve.

Every Sunday morning at six a.m. we present a fifteen minute radio program over stations W.C.A.O. 6 A.M. and W.X.Y.V. 103 F.M. in Baltimore.

This program is known as "Your Best NEIGHBOR" and is the oldest continuous public service program on W.C.A.O.

1981 marks our twenty second year of continuous weekly broadcasts.

"Your Best Neighbor" program acquaints our audience with the new products of pharmacy and their many uses.

It gives them a keen insight into the tremendous research work being done by our great pharmaceutical manufacturers.

We give them many thoughts and ideas which will protect their health, and make life more pleasant.

We strive continuously to let the public know that the community pharmacist is ever ready day or night to supply the essential drugs and medicines that spell the difference between life and death.

We also made a supreme effort, to capitalize on any outstanding effort, that might make the public realize, that pharmacy was vitally important to them and that the pharmacist was still "Their best neighbor".

On our radio program, "Our Executive Director Speaks", we told our audience how active and busy our executive director, Dave Banta, was at all times, we explained his many administrative projects, his legislative programs and his many executive duties. Despite all this Dave runs a successful and efficient organization.

We talked a lot about pharmacy, and sometimes we are prone to wonder if anybody does anything about it or for it? Let me tell you that one of our most enlightening programs was dedicated "To the study of Pharmacy as a Career". This was a brilliant program, capably and intelligently handled by a member of our committee. It outlined in great detail the past, the present and the future of pharmacy. This intelligent discourse on pharmacy as a career was most complete and instructive to our embryo pharmacists.

During heart month we conducted a program which described the many drugs and remedies employed today in the treatment of various heart ailments. The program was highlighted with the important advice, that all of these remedies could be obtained on prescription only, from "Your Best Neighbor", the friendly pharmacist.

In an effort to create a more harmonious and productive relationship with the dental profession, we presented a program during dental care week which told in great detail, the importance of correct dental care and treatment. We felt this type of cooperation with a closely allied profession, was a splendid opportunity to capitalize on potential prescription work in the future. It was just another way of giving the pharmacist valuable publicity at no expense.

One of our most interesting programs was one in which we asked the question, "Why do you patronize your favorite pharmacy?". Everyone answering received by return mail a vitamin chart discussing the functions and uses of the various vitamins. From the answers we found most people patronize their pharmacy because of confidence in the pharmacist, not because of bargain prices. The integrity of the individual pharmacist is unquestioned. If the price alone were the factor, the customer would be attracted to the store front with the most flamboyant signs. Professionally, this is not the case.

It has been the thinking of your public relations committee, that the most important week during the year for professional and retail pharmacy is National Pharmacy Week. During this week your public relations committee exerted every effort at its command to bring to your customers attention how important you, the pharmacists is to their very existence. Here is where all of your publicity media were united in a hard hitting force that did its best to tell one and all that the pharmacists was truly their best neighbor. The pharmacist is the one who has the best opportunity for meeting the public, your customers, face to face, and of telling them about drugs, the biggest bargain in their family budget. Only the individual pharmacist can successfully put pharmacy's story across. Organized pharmacy can direct and help with the tools, but the responsibility is yours.

During Poison Prevention Week, your committee presented a program, which discussed the poisons most responsible for poisoning in the home. How important it is to keep poisons out of the hands of small children. We explained how to eliminate poisonings in the home. We told of the important part the pharmacist plays in telling his customers about dangerous drugs. Our informative program on V.D. told our audience, that four Americans are stricken by V.D. every minute. Most of the victims are under 25 years of age. Clearly not enough people know the facts about venereal disease. We told our audience that you must tell them, show them, and educate them to stamp out V.D.

Our programs on drug abuse have been most informative in a sincere effort to keep the potential addict from getting hooked. We know that drug abuse goes beyond ruining individual lives, its evil effects radiate outward and settle on society like a choking dust. Your committee feels that it has done its work well, if it can stop one person from taking that first step along the road that leads to nowhere.

During the past year your committee was very active in supporting the elder ed program, which is a program of drug information and pharmacy education, developed to give the senior citizens knowledge about their drugs and health.

Time and space do not permit me to describe each and every radio program presented on station W.C.A.O. during the past year, because there were 52 of them. But I can tell you this. These programs will always say that the Pharmacist is, has been, and always will be the public's "Best Neighbor".

For their cooperation, advice and assistance, I would like to thank Mr. Joseph Cahill, Manager of radio station W.C.A.O.; Mr. Ron Riley, Public Service Director of Radio Station W.C.A.O.; Mr. Larry Wilson, Program Director of radio station W.C.A.O.

For his ideas and encouragement, I want to particularly commend our Executive Director, David Banta. For their kindness and cooperation, I sincerely thank Mrs. Sharon Spies and Mrs. Mary Ann Frank in our Association Office.

No public relations program in the world can succeed if the promoter does not believe in his cause.

Every Pharmacist is a public relations man for his profession, and the job he does with his customers depends directly on his attitude toward his profession.

I should like to close leaving this thought with you.

A leaf hits the ground and dies, a seed takes root and grows. Are you leaf or seed?

Plans Complete for Centennial

William Skinner

The Committee has continued its planning efforts toward the 1982 Centennial year through two meetings and the individual efforts of several members.

During the past few months, the *Maryland Pharmacist* has published in serial parts, a History of Pharmacy article by David Cowan through the auspices of the American Institute of the History of Pharmacy. Also, because of the interest of AIHP in placing a commemorative plaque at the site of William Procter's birthplace in Baltimore, your Committee attempted to research the precise location. Unfortunately, street address records for 1817 are no longer available in any public library materials and we were unable to provide an address to meet AIHP criteria. The research did disclose that Proctor, named at his death as the "Father of American Pharmacy", was probably born within walking distance of the Kelly Building and the Baltimore campus of the University of Maryland.

Because Proctor was only born in Baltimore and carried on his professional activities outside of Maryland, the Committee is continuing to consider additional persons to honor during the Centennial year with a commemorative program. One person under consideration for the honor is David Stewart, the first pharmacy professor in the United States (Maryland 1844-1846).

The Board of Trustees approved an additional expenditure of funds to purchase an apothecary jar bearing the MPhA banner as a fund raising item. A flyer describing the jar, suggested uses and prices is available for your information. Our attempt to have these available at this Convention was thwarted by a labor strike at the glass company.

Additional items are being sought for resale to members to commemorate the 100th anniversary. These will be made available at a series of regional and county meetings this Fall aimed at rejuvenating the local associations.

The basic outline of the 1982 celebration activities will include a kickoff event in conjunction with the Baltimore Metropolitan Pharmaceutical Association dinner/dance in early 1982. This will be followed by a special dedication of the Olive B. Cole museum at the Kelly Building at the Spring Regional Meeting, at which time we plan to install a sign in front of the Kelly Building announcing the opening of the museum to the public and unveiling appropriate memorials to Proctor, Stewart and others.

Our annual convention program in June 1982 will be receiving special support from the Centennial Celebration Committee. Some of the special events already committed include a patriotic fanfare opening ceremony (Lederle Laboratories); old time convention badges (SK'F); a highly sought after three hour personal communications program (Upjohn); souvenirs from Owen-Illinois and others; and a Seminar to help pharmacists speak to civic clubs and high school classes.

At the Fall Regional Meeting, held in conjunction with the October 5, 1982 Founding Day, there will be special ceremonies with public officials and continued emphasis of a new MPhA Speakers Bureau program, using the Elder Ed program of the College as a model.

A series of articles will be run in the *Maryland Pharmacist* during the year to supply a memory list of names and events of the past 100 years.

Throughout the year, the Association will be preparing special news releases supplying historical information and we hope to have a school poster contest for members to use as a local promotion of proper drug use awareness. These activities and the sale of the new USP Publication "About Your Medicines" will, the Committee believes, give pharmacists new public service visibility as drug experts in their communities. If enough pharmacists participate in these activities, our 100 year celebration will indeed be memorable.



Betty Alpern was installed as President of the Ladies Auxilliary of the Maryland Pharmaceutical Association.



Irvin Kamenetz (center) has a pile of used crabs before him as a result of the convention crab feast at the Berlin Fire Hall. Both Maryland and Delaware pharmacists, family and friends enjoyed all the crabs they could eat.

Pictures courtesy of
District Paramount Photo

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Legislative Committee Report

Four steps forward, three steps backward. The numbers might not be accurate but hopefully the idea is correct. Each year your Association is represented in Annapolis mainly by Dave Banta and other Association members who give untiringly of their time. At session's end, we weigh the results. Hoping we have won more than we have lost. This year we think we came out ahead. Our reaction to harmful legislation is better than our promotion of new legislation.

One of our frustrating failures in this year's session was Repeal of the Price Poster Bill even with fine testimony from Dave Banta and Paul Freiman and with no apparent opposition our Repeal Bill got hung between two committees and died a slow death. All our efforts to convince the committees of the poster's ineffectiveness went for naught.

We lost a few crusades:

1. Altering handgun violation penalties
2. Licensing dispensing physicians
3. Requiring non-pharmacy outlets to register syringe users.
4. Third party payment problems.

But we won some too.

1. We passed the update of the entire pharmacy bill with all MPhA recommendations.
2. The repeal of the ineffective drug bill
3. We opposed mandatory profiles
4. The Board of Pharmacy received the option to impose fines instead of revoking licenses.

Looking back over a few years, I remember the times before PharmPAC, before the Mel Rubin's, the Paul Freiman's, Don Fedder's and Dave Banta's and many others and can easily say "We've come a long way". We have a very capable representative in Annapolis who with each succeeding year acquires a

greater rapport and stature with the legislators. Because over the last 10-15 years state and federal governments have become more interested in our profession, it behooves the Association and you its members to become very politically involved. What we have done is good. What I hope we will do will be better.

Two stormy problems present themselves in our immediate future. The first, third party reimbursement problems and second because of Reagan budget slashing, medicaid payment changes.

So let's hope that this time next year through Association efforts we can say, we came out ahead.

Milton C. Sappe
Committee Chairman

Report of the Tripartite Committee

The Tripartite Committee had many stimulating and though provoking topics come before us this past year which lead to many open and frank exchanges of ideas and viewpoints. The two items that led to the most extensive and lively discussions were the Community College of Baltimore's attempt to initiate a "Pharmacy Technician" program and the exchanges of opinion concerning the "Doctor of Pharmacy" designation. Dave Banta did his usual superb job in keeping this Committee well informed of all legislation that would have affected our profession during the past session of the legislature. I would also like to take this opportunity to encourage all pharmacists to make use of this Committee as a sounding board for any issue that you feel would affect the entire profession of pharmacy so that we can strive to provide a well informed, organized and united front.

Harry Hamet

Necrology Report
School of Pharmacy — Deceased Alumni
Since June 1980

Louis Blitz
 Dr. Fitzgerald Dunning
 Paul F. Flynn
 Melvin L. Heer
 Herbert A. Katz
 LeRoy E. Lexel
 Morris Kramer
 John F. Krause
 Meyer Kushner
 Thomas E. Lane, Jr.
 Joseph Levin
 Luther E. Little
 Lessel L. Manchey

Ph. G. 1934, B.S. 1935
 Associate member
 Pharm.D. 1911
 Ph.G. 1931
 Ph.G. 1927
 B.S. 1949
 Ph.G. 1923
 B.S. 1969
 Ph.G. 1930
 B.S. 1970
 Ph.G. 1926
 Ph.G. 1924, M.D. 1928
 Ph.G. 1928, B.S. 1929
 M.S. 1931, Ph.D. 1935
 B.S. 1936, M.S. 1939
 Phar.D. 1915, Ph.D. 1942
 Ph.G. 1928
 B.S. 1937
 B.S. 1937
 Phar.D. 1908
 Ph.G. 1934
 Ph.G. 1917
 Ph.G. 1931, M.D. 1935
 Ph.G. 1921
 Ph.G. 1929
 Phar.D. 1913
 B.S. 1936

Bernard P. McNamara
 Benjamin Mellor
 Ruth Millard
 Gordon A. Mouat
 Leo M. Musacchio
 Maurice I. Parelhoff
 Nathan Plovsky
 Vaughn M. Richardson
 Harry M. Robinson, Jr.
 Joseph J. Rosenberg
 Abraham Milo Sach
 Harry L. Schrader
 Morris R. Yaffe

MSHP Remarks to Convention

I wish I was able to speak to you in person today, but unfortunately my schedule would not permit me that honor. I would like to take this opportunity however, to offer you my greetings on behalf of the Maryland Society of Hospital Pharmacists to wish you a very successful convention.

I believe that the Maryland Society of Hospital Pharmacists and the Maryland Pharmaceutical Association have worked diligently during the past year for our mutual goal: the promotion of Pharmacy as a profession and the protection of our collective and individual rights as pharmacists. We have continued to work together in Continuing Education and the Tripartite Committee with the School of Pharmacy. Through these mechanisms, and especially through Dave Banta's office, we have developed a rapport and understanding of each other's positions that is so essential to the growth of pharmacy in the State of Maryland in this decade. It is extremely important that pharmacy practitioners continue voicing their opinions concerning education of pharmacists and curriculum and deletions.

I personally believe that the road to success in the practice of pharmacy during the next ten years will be paved by education. The education that I speak of is the education of patients, physicians, educators, and other professionals by the pharmacist. I believe the pharmacist's role is teaching other professionals and patients about drugs and related subjects. Unless the pharmacist becomes an educator, efforts to move our profession forward will meet with failure. We must keep in mind that it is not what we call ourselves that is important, but it is by our professional practice that we will be recognized by others.

Patrick H. Birmingham
 Chairman

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Some of the participants in the Tennis Tournament prepare for the next match. Joint competition between the two states also included an impromptu volleyball game on the beach the results of which we will not report.



The Simon Solomon Seminar on Economics featured Certified Financial Planner John Rodgers who provided his audience with a comprehensive look at financial planning.

Executive Director's Report

It has always been difficult for me to adequately summarize the accomplishments of the Association over the year in only a few words. Each year seems to bring new challenges, problems and their solutions. Like every other organization in our society, this Association endured the hardship of inflation over the past year. We have attempted to provide increasing services and benefits to the members while containing spiraling costs. Items such as utilities and postage, to name just two, will continue to rise in the future. Yet we will also continue to build this Association into one that deserves your pride.

The backbone of the Association, of course, are the men and women who volunteer their time and efforts to serve as officers, trustees and on the Committees for the Association. It is the spirit and determination of these individuals which really makes the organization productive and growing. This spirit is intangible but absolutely essential to our success. I can say that working with the officers, trustees and committee chairpersons over the past year has been a great personal pleasure for me.

The specific reports of these individuals will summarize the highlights of the past year and detail the progress we have made. My purpose here is to emphasize the point that this progress is due largely to their individual efforts. Working through the Association we can accomplish a great deal in achieving our goal of improving the profession and serving the public health.

As we approach our 100th anniversary it seems appropriate to reflect on those who have gone before us and who have given us a heritage of strength and accomplishment. Maryland's list of "firsts" in Pharmacy is impressive and I have no doubt that our tradition of innovation will continue in the decades ahead. Thank you for allowing me to be part of this experience.

David Banta

Third Party Committee

My year as chairman of the Third Party Committee has confirmed my previous impressions of pharmacy and has left me saddened. With the exception of a few of you who stand firm for what is just and equitable, the rest remain silent and passive and are insuring our profession increased managerial and financial burdens in the future. All the organizations, committees and workers are only figureheads until you the members place your support behind them.

I wish to extend my sincere gratitude to those few who took a stand and made their presence and pharmacies importance known. Though their success was limited, it has laid the groundwork for a better future for all of us.

We are prohibited by law at this time from pursuing unified action to achieve equitable financial remuneration for our professional services. There is only one avenue available to us which will allow us to obtain what is justly ours, that is by legislation. For the multitude who fear to become involved and fight with us as a group, there is a way. The MPhA is constantly introducing legislation which is designed to insure your future survival. The Maryland version of the Georgia Bill was introduced and has been tabled for summer study. As you should be aware the Georgia Bill has many key guidelines for the protection of Pharmacists filling third party prescriptions including the usual and customary fee provision.

Three other states have passed this bill. It will take an all out effort by every pharmacist, their relatives and friends, and their patients to contact their elected delegates to insure the passage of this Bill and others to come. The past has shown us that this is the only means left to us to protect our future.

You must work with the Association to promote legislation beneficial to our profession and defeat that which is detrimental. It is your only hope. If you don't act to protect yourselves and your fellow pharmacists, I can only condemn you for the harm you yourself will create for all of us by your passiveness.

Donald Schumer
Committee Chairman

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Speaker of the House

It is with a great deal of pleasure to deliver this report as the Speaker of the House of Delegates at our last Convention of the first century of our Association's existence.

The Association has had two Regional meetings prior to this Convention. The 1980 Fall Regional was held in October at the Kelly Memorial Building. Marvin Friedman, who has since moved out of the state, returned to receive the NARD Leadership Award and Ronald Lubman was the recipient of the Squibb Past President's Award.

State Delegate Paula Hollinger presented background information on the handgun legislation she introduced in the General Assembly and of the need for increasing the penalties for handgun crimes. Although her Bill, actively supported by the Association, never passed, Delegate Hollinger has high hopes for the next session.

The next speaker, Robert Blount, Chief Investigator of the Medicaid Fraud Control Unit spoke on the structured mission and general activities of the Unit.

The two proposed Amendments to the Constitution and By Laws were read and Approved:

1. Under Article V, Section I, eliminate reference to the Secretary of the Board of Pharmacy as an ex-officio member of the Board of Trustees.

2. Delete Article X in its entirety concerning TAMPA, which

has disbanded.

The 1981 Spring Regional Meeting took place in March at the International Hotel at BWI Airport with the largest attendance in recent years and was highlighted by the great "P.D. or not P.D." debate. David Clark, P.D., Executive Director of the Indiana Pharmacists Association, made the case for the Doctor of Pharmacy designation as a forward step for the profession. William J. Kinnard, Ph.D., Dean of the University of Maryland, School of Pharmacy, masquerading as Benjamin Franklin (complete with patent buckle shoes) visually and verbally brought home his point that this might be a backward and inappropriate action. The spirited audience participation that followed is a prelude to the interest expected at this Convention with the recommendations of the Professional Designation Study Committee.

The business portion of the meeting was limited to Committee Report and a second affirmative vote of the two above mentioned Constitutional Amendments.

Much still remains to be done in our quest for professional and personal recognition. This can only be achieved by the active support and involvement of all pharmacists in the State.

My special thanks to our Executive Director Dave Banta for all his advice and support.

Respectfully submitted,
David Serpick

The Dean's Message

Messages of this type most often review activities of the school over the past year and highlight the significant accomplishments that have occurred. I am not going to recapitulate those activities except to indicate how pleased I am with the strong program that the Maryland Pharmaceutical Association has developed over the past few years. The leadership of the officers and of the executive director have made the association a model for other states to emulate. I am particularly pleased with the encouragement that is given to our students as they become involved in association activities either as members of SAPHa or through their efforts as student externs. This kind of involvement can only serve to strengthen the association in future years.

As I indicated, this report is not about the past instead it is about the future. While the school is taking a neutral stance on the discussions regarding designations for pharmacists, it is not doing so in regard to relationships between education and the practice of our profession.

The faculty has agreed to initiate a revision of the baccalaureate curriculum this coming fall. It will have a number of unique educational innovations and is designed to build on the strengths already in existence in our present program. The student will be able to have more experiential learning with some externship occurring in the first year of the program. The student will also have the opportunity to develop more communication and management skills. In general, we have been pleased with the quality of students produced by the present program and certainly hesitate to make major changes in it, but it is apparent that some of them are important enough to risk the academic tampering that will occur.

We will be developing an advisory committee of practitioners that will provide their expertise and critical analysis

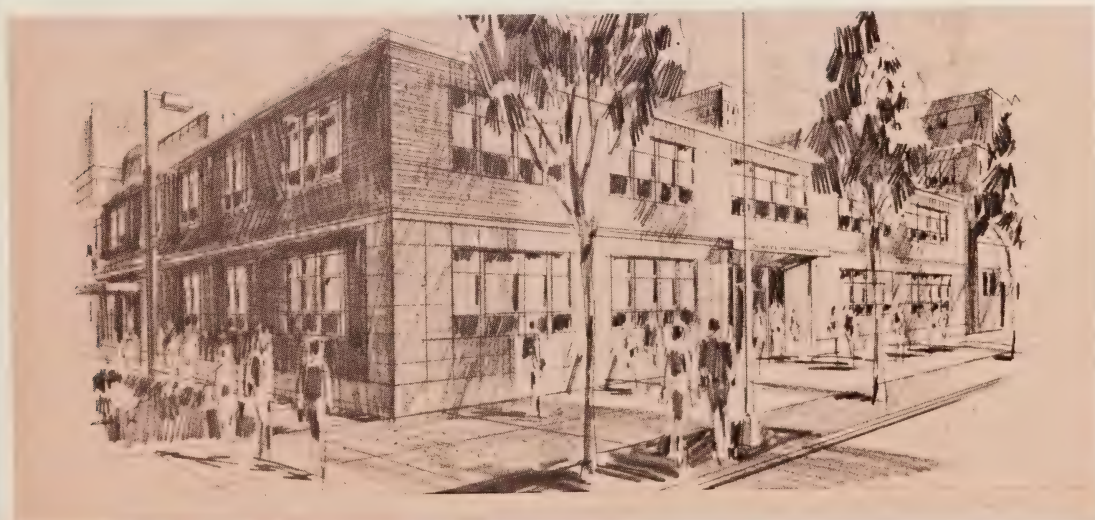
to me and the faculty on matters related to the relationship of our educational programs to the practice of pharmacy and how we can use the resources of the school to help improve the practice of pharmacy in the State. This is not meant to replace the Tri-Partite Committee but is designed to deal with different issues.

It is hoped that the new graduate program in Pharmacy Practice and Administrative Sciences will be approved by the University and the State Board of Higher Education during the coming year. This will provide the school with the opportunity to provide programs leading to the masters degrees in the areas of community and institutional practice as well as the Ph.D. degree in the area of the administrative sciences. A key part of the program is the fact that research in this program will be directed toward pharmacy practice and will have a significant impact on the future of the profession.

Finally it is important that the school continue to examine how we can help to work with the individual practitioner in the improvement of his or her skills. We will need to institute discussions during the coming year that highlight such things as what skills do need to be renewed or developed within the practitioners? What would be the educational approach for that effort (continuing education certificate programs, etc.), where would this education take place, etc.? These discussions will require joint efforts between the members of the faculty of the school and pharmacy practitioners and we hope that we will have a very significant outcome of those discussions.

William J. Kinnard, Jr., Ph.D.

Dean, University of Maryland, School of Pharmacy



Thanks, Northeastern University

College of Pharmacy
Boston, Massachusetts



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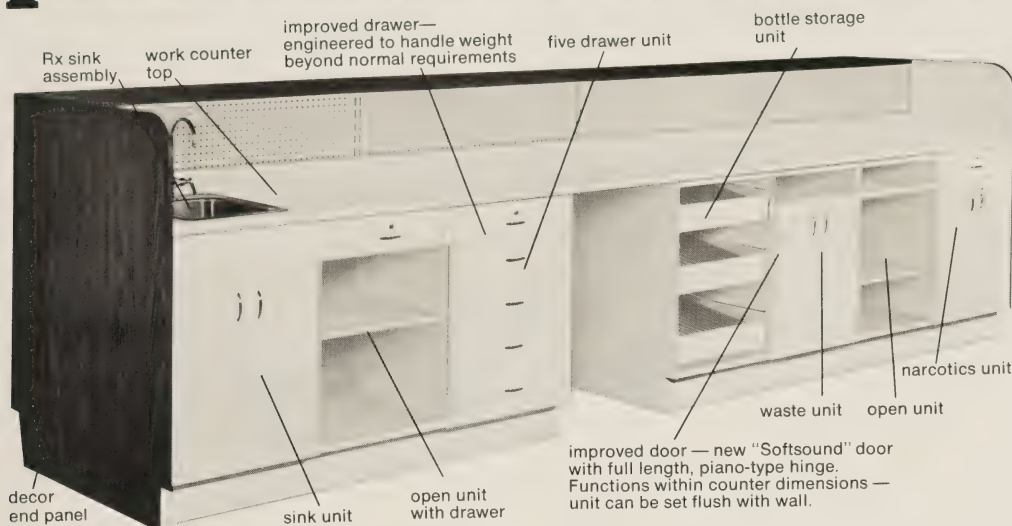
They were bright, curious, professional and very excited about their careers.

It was a good day. And one way we know of starting—and keeping—a dialogue.



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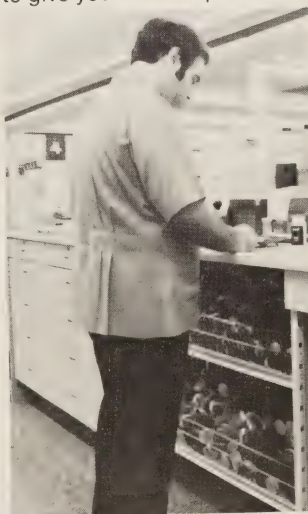
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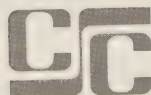
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Continuing Education Coordinating Council

The Continuing Education Coordinating Council is comprised of members representing the MPhA, Maryland Society of Hospital Pharmacists and the University of Maryland School of Pharmacy. It is another excellent example of the ways that cooperation can serve in accomplishing mutual objectives. Last year was an extremely successful year for the Council. The Council pharmacists planned and executed six complete continuing education seminars for Maryland pharmacists and at the same time made available a series of correspondence and cassette programs. As the council continues to grow and present new programs, it has learned what pharmacists in Maryland desire in continuing education programming and is working to improve our future offerings. The Council currently has accumulated a modest financial reserve as a result of registration and manufacturer's support of past programs. This allows the Council members, who are all volunteers from the three organizations, to plan more ambitious programs in the future.

The Council has already solicited support from manufacturing interests to support our 1981-82 programs. The Council has now outlined a series of interesting and timely programs that include seminars on oncology, pulmonary diseases, pediatrics and obstetrics, and personal/personnel management. In addition, the Council is planning two "road shows" that would be used throughout the State. These would be on new drugs and a repeat of last year's program on parenteral nutrition.

Again the Council is reaching out to other organizations and will be presenting some of these programs in cooperation with AZO, Howard University and local associations throughout the state.

As Chairman of the Council, I would like to thank each of the members of the Council who have given voluntarily a significant commitment of their time to ensure that quality continuing education is available to the pharmacists of Maryland. These individuals work very hard on your behalf.

I would urge any pharmacist who has a comment about the Council's work to be sure to provide that feedback to the Council. We are attempting to remain sensitive to the educa-

tional needs of Maryland Pharmacists. If you are interested in assisting the Council, please contact me for more information about the work of the Council.

Thank you.

David A. Banta
Chairman

Industry Relation Committee

The Committee met a number of times throughout the past year to consider new and on-going projects on behalf of the membership. On-going projects included the "Day in the Pharmacy" experience for new manufacturing representatives, and the work of the Committee as an ombudsman for pharmacists who have an inquiry for manufacturing interests. In addition, the Committee also conducted another campaign to remind pharmacists to return out-dated merchandise and provided, through the *Maryland Pharmacist*, a model return goods policy and cover letter. Of particular concern to the Committee was the fact that some few companies had marketed prescription drugs to pharmacists in Maryland without receiving approval from the FDA when required. The Committee had published a list of products by generic company in the *Maryland Pharmacist* as an aid to pharmacists in drug product selection.

The Committee met with the Associate General Counsel of the Proprietary Association to discuss a third class of drugs for pharmacists, expiration dating on the packages, and reformulation of ingredients without notification to the pharmacist or patient.

The Committee is currently conducting a survey of OTC manufacturers to determine which products have been, or will be reformulated and will publish the results for the benefit of the members.

It was a productive year for the Committee and I enjoyed serving once again as Chairman. I wish to thank the members of the Committee for their time and effort.

Mark Golibart
Chairman



Baltimore has been selected as the site for the 1982 American Society of Hospital Pharmacists Annual Meeting. It will be the 39th Annual meeting of the hospital pharmacists and is scheduled for June 6-10, 1982. The MPhA, MSHP and School of Pharmacy will be making preparations to welcome the Society as it arrives in Baltimore during the MPhA Centennial Celebration.

He knows the practice of pharmacy inside and out.

In fact, during the years since he graduated from pharmacy school in 1964, he has done everything but teach it.

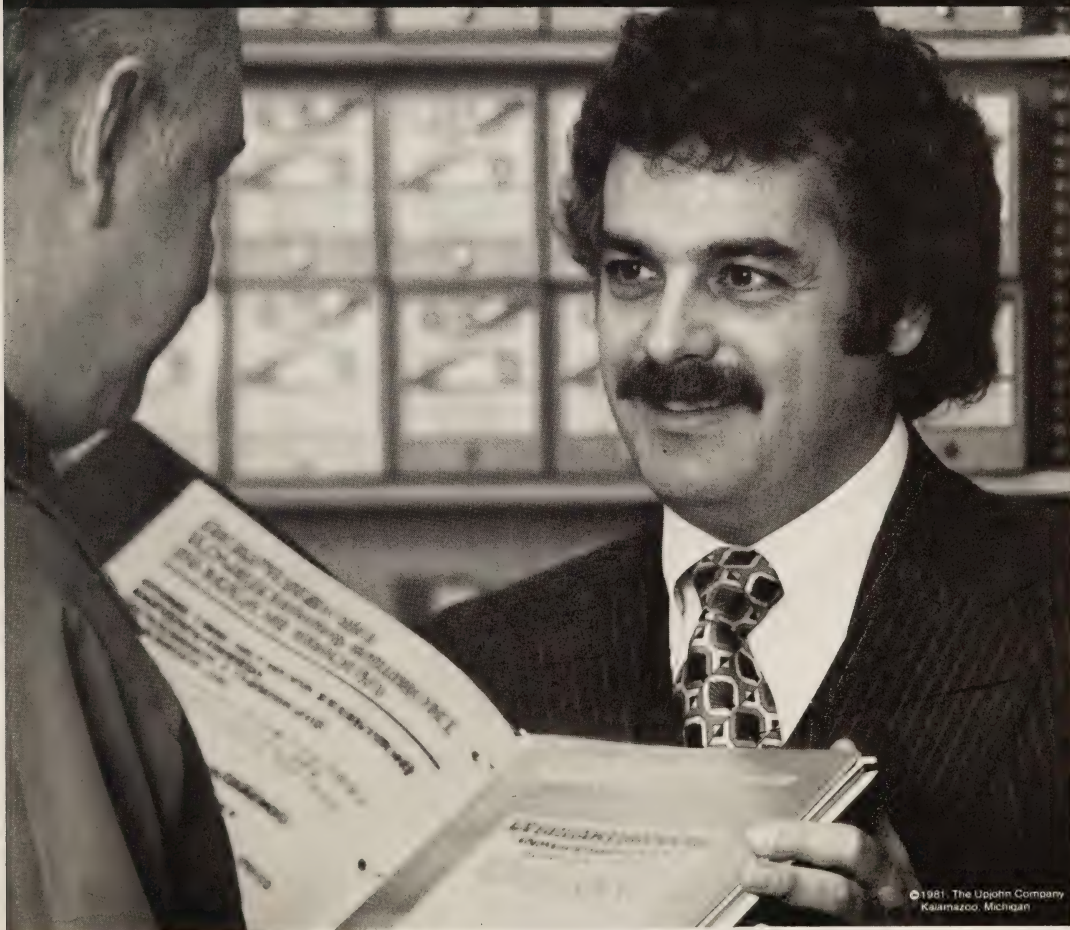
Before joining Upjohn in 1973 as a sales representative, Vince worked as a pharmacist in a community drug store; in a small chain drug store; in a large chain drug store; and as assistant director of pharmacy at a large hospital.

This experience has given Vince a strong personal insight into the needs of other pharmacists. His background, training and continuing education all help Vince provide information and service to pharmacists in his area.

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Classified Ads



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Available from the MPhA Office

- Notification for the patient under the Drug Product Selection Law
- Heart Shaped Stickers — no charge
- Information on the Blue Cross Blue Shield Major Medical Health Insurance Program
- The Association's Employment Clearinghouse, helping pharmacists and employers find one another
- IC collection help
- Information on the NEW USP/NF on sale from MPhA.

For these and many other services, contact Sharon at the MPhA Office. (301) 727-0746

Any Pharmacy having Oncho-Phytex (recently discontinued) please contact Doug Haggarty at The Medicine Shoppe 282-8388. Medication needed for patient.

I need Varidase (laderle). Please call 574-1440. Fuller Pharmacy.

Part time help wanted in active community store in Baltimore. Flexible schedule. Contact Box 15, MPhA office, 650 W. Lombard St., Baltimore 21201.

The University of Maryland School of Pharmacy is interested in including 4 antique pharmacy fixtures in its new building, planned for completion in 1983. Anyone interested in such an idea is invited to call the Dean's Office, 528-7650.

The **Elder Ed** program has developed the following brochures for older consumers: "Sublingual Nitroglycerin Tablets, some do's and don'ts", "Vitamins are not Enough!", "How to Select Your Pharmacy", and "You and Your Medicines". For additional information contact Elder Ed at (301) 528-3243.

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Sacred Heart Hospital	777-8383
Cumberland	
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University of Maryland Hospital	528-3111
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Memorial Hospital	822-9198
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calendar



SEPT. 17 — MPhA/CECC Fall Management Seminar and Regional Meeting

SEPT. 21-24 — NARD CONVENTION — San Antonio

OCT. 11 — MPhA DINNER THEATRE — "WEST SIDE STORY" TOBEY'S in Columbia

OCT. 18 — Alumni Association Oyster Roast — Overlea Hall

OCT. 30 — MPhA Oriental Odyssey — 14 night trip

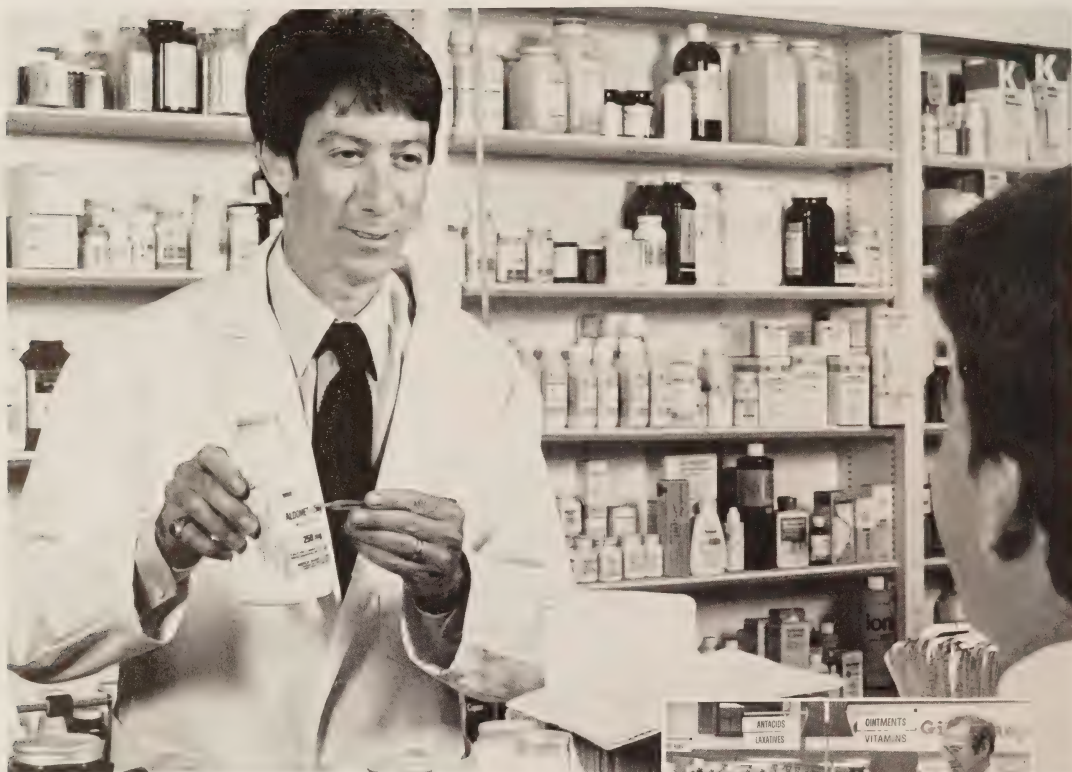
Every Sunday Morning at 6:00 a.m. listen to Charles Spigelmire on WCAO broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore.



Members of the Baltimore Veteran Druggists (BVD's) gathered on the shores of the Magothy River at the estate of Chris Rodowskis for their Annual Crab Feast held May 20, 1981.

Pictures courtesy of District Paramount Photo

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THE MARYLAND PHARMACIST

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Patient Information, PPI's and You

— William M. Heller, Ph.D.

Why the "P.D." Designation

— Lee Ahlstrom

The Founding of MSHP

— Norman Pelissier

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
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The director of one of Maryland's county drug abuse counseling centers contacted me last month with a concern. At one of his group sessions with ex-addicts, who are pressing for greater controls for Schedule V exempt narcotics, a consensus was reached. He quotes a spokesman who said, "I have been addicted to codeine for four years due to the fact that it is easy to obtain throughout Maryland with the exception of Baltimore County and Baltimore City. All you have to do is sign a narcotics register book." The ex-addict went on, "My addiction has had its toll on my life in many ways. I spent most of my earnings on it. I've lost a lot of friends . . ."

Controls on exempt narcotics is a very emotional issue for many pharmacists. I think the existing controls are adequate, but they are not adequately employed by all pharmacists. There are some pharmacists who dispense exempt narcotics only to individuals that they have known and trusted for years, depriving unknown, but well intentioned patients. A few years ago there was a court case where a pharmacist was successfully sued because he discriminated against an individual whose appearance, in the pharmacist's judgement, did not seem consistent with his purported use of exempt narcotics. At the other extreme, there are pharmacists who indifferently relegate to clerks the responsibility of dispensing these preparations, giving little or no concern to who receives them. We are truly in a dilemma.

On the one hand, we risk being unresponsive to people who need the medication and would otherwise have to go to great expense to acquire these preparations. On the other hand, if we make the drugs too readily available, we risk being the subject of law enforcement action and eventual legislative infringement upon our professional prerogatives. Some may argue that we would be better off with Schedule V narcotics on prescription only, because we would not be put in the position of deciding to whom to dispense or not dispense. This is the easy way out.

All pharmacists should have a concern. The entire profession will suffer the consequences of tighter controls. I, for one, still have hopes for a third class of drugs, to be dispensed by pharmacists only. That is not likely to occur, however, if we can not demonstrate that we handle Schedule V substances responsibly. Let's not relinquish what we have. Let's protect our interests in this public trust. I am hopeful that the incidence of pharmacists indiscriminately handling Schedule V controlled substances is low; but, that should not preclude us from striving for greater compliance with the intent of the CDS regulations and self-policing. If you are aware of some pharmacists who are indiscriminately dispensing Schedule V narcotics, you need not confront them. Your State Association has a mechanism to deal with these colleagues. A dedicated Peer Review Committee represents all of our interests and has been very successful in the past in resolving issues brought to its attention.

Philip Cogan,
PRESIDENT



Patient Information, PPI's

and you

by:

William M. Heller, Ph.D.
Executive Director
The U.S. Pharmacopeial
Convention, Inc.

The Food and Drug Administration proposes to transform from the domain of patient education to the realm of legal labeling the individual efforts of physicians and pharmacists to provide written patient drug use information.

Patient information for prescription drugs has been assumed to be the responsibility of practitioners.

The Durham-Humphrey Amendments to the Food, Drug, and Cosmetic Act in 1951 reinforced that conception by exempting manufacturers from that responsibility for drugs sold only on prescription. The basic principle was that all drugs should be sold over-the-counter with adequate information for the patient in the labeling. However, if the drug was too dangerous for self-use, or if it required extraordinary means for administration such as a parenteral injection, or if the disease for which it was used was not one that the patient could be expected to treat himself, then the drug was restricted to dispensing on prescription and the manufacturer was relieved of providing patient labeling.

Instead, for prescription drugs the manufacturer had only to make full information available to prescribers.

Ten years later FDA ruled that it must be stuffed in every package; thus prescribers' information became known as the package insert.

It is called "full disclosure" information — all the information the prescriber needs in order to prescribe it safely and effectively: brief discussions of how the drug works, the uses that FDA agrees the manufacturer has proved scientifically that the drug is good for, side effects of the drug that have been reported to the manufacturer or reported in the medical literature, situations in which the drug should not be used and other precautions to be taken in using it, dosage schedules, the kinds of dosage forms provided and any special information about them such as storage conditions or mixing with other drugs.

Deficiencies In The Package Insert System

There are two fundamental deficiencies in the package insert system as an information system, in my view. One is in the way the words are written and the other is in the way they are distributed.

First, the words are written by each manufacturer, subject to FDA approval. That means they can and do differ from brand to brand. That also means no input from the medical community at large. Thus the package insert does

not keep up with advances in medical use of the drug unless the manufacturer takes it upon himself to study those new uses and prove scientifically to FDA that the drug is effective for a new use or a new dosage schedule. Since prescribers are already using it based on their assessment of the medical literature and the consultation of colleagues they respect, the manufacturer is already achieving augmented sales and has little incentive to spend money to convince FDA to allow a change in the package insert.

Second, the package is on the shelf of the pharmacy, not on the prescriber's desk. The person for whose use the package insert is intended rarely sees it. This deficiency has been partly overcome by the commercial book, *Physicians Desk Reference*, which reprints the information and guarantees to send the book free to several hundred thousand prescribers. The drug manufacturers are generally agreeable to paying *PDR* a fee per page or column-inch for this service to distribute information about their most important and largest selling drugs, but not for lesser items. Thus not all drugs are included in *PDR*, some manufacturers do not use it at all, and some pay only to list the names of their products and do not provide full disclosure information.

From that point on, the provision of prescription drug use information to the patient has been considered to be the responsibility of the prescriber. He knew the drug, presumably, and he knew the patient, presumably. Therefore, he knew what information the patient needed about the drug, considering why he was prescribing it, what else the patient was taking or doing, and what was wrong with the patient.

Some physicians, for treating certain problems, have developed written protocols that they give to patients — mixtures of information about the disease condition, the drugs being used, and other instructions for the patient such as diet and activities. Generally, however, the drug information imparted by the prescriber has been oral and brief and the only written information has been that which he directed the dispenser to put on the prescription container label.

The Pharmacist's Role

The role of the dispensing pharmacist has gone full circle through these years. When the 1951 Amendments resulted in most of the drugs being relegated to prescription status and the manufacturer having to make the information available only to the prescriber, "Ole Doc" pharmacist was ignored. he got the message that he was not supposed to talk to patients about prescribed drugs any more, not supposed to inter-

fere with the physician/patient relationship. Furthermore, the number of prescriptions per day that he was expected to fill went up to the point where he did not have time to talk to the patient anyway. His income was reflected in the number of prescriptions filled, not on the time spent with each patient, so he had little incentive to talk to patients and explain any written information he might have prepared.

On the other hand, with practically every prescription being filled with a manufacturer-prepared dosage form and the pharmacist's compounding function reduced to nearly zero, pharmacy became a profession hungry for additional functions more useful than counting and pouring the manufacturers' preparations. Since the package inserts resided along his shelves and, moreover, since they were considered biased in favor of the manufacturer, the provision of an unbiased, centralized drug information service was a natural. At first, this type of service was in the organized pharmacy/medical staff efforts in hospitals. It led naturally to the pharmacist becoming more involved with the drug therapy of the patient. Clinical pharmacy became a by-word, and by now it has progressed to the pharmacist serving, the drug information needs of patients outside the hospital, in a generic sense; i.e., regardless of who prescribed the medication and how many different prescribers the patient sees, the pharmacist has a role in providing information that the patient should know about each drug in order to use it most safely, regardless of why it was prescribed.

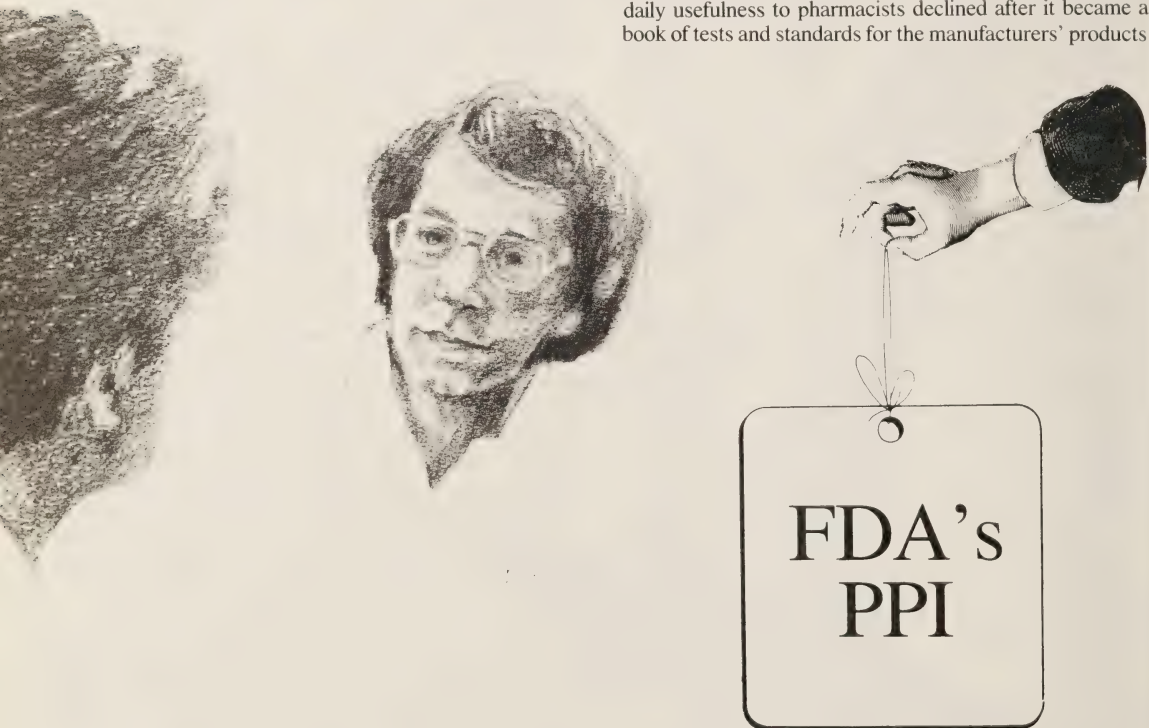
Practically every organization in pharmacy has said repeatedly in recent years that the pharmacist has a role in providing information to patients. Yet pharmacists aren't filling that role. Study after study reveals failure of pharmacists to fulfill the counseling — information providing — role. Patients don't expect it of them. Physicians don't even want them to.

That's where the United States Pharmacopeia came into the picture. If the pharmacist is going to provide information to the patient about a prescription drug, the prescriber needs to know what he will be saying so that the patient does not become confused by differing data.

The USP's Role

The Pharmacopeial Convention is the only national organization of pharmacy and medicine with a large base. It is composed of representatives of each school and each state and national association of pharmacy and medicine. Several agencies of the federal government, including the FDA, are members of the Convention also. It was the logical group to provide dispensing guidelines and patient information from a national bi-professional base. Furthermore, the prestige of its century-and-a-half history and the recognition of its standards of strength, quality, purity, packaging, and labeling by the national and state food and drug laws gave added support to the pharmacist who might be challenged by a prescriber for interfering in the latter's relationship with his patient.

Although the Pharmacopeia is the most widely distributed, user-purchased book in pharmacy and medicine, its daily usefulness to pharmacists declined after it became a book of tests and standards for the manufacturers' products



rather than a recipe book for the compounding pharmacist. Inclusion of information about a drug's use was intended to keep the book useful to the pharmacist and to maintain this inherited vehicle of communication between pharmacy and medicine.

Since the turn of the century the Pharmacopeia had included doses. A half century later, categories of use and dosage form strengths available were added. Notes and admonitions to the dispenser gradually appeared in many monographs. This natural evolution of drug usage information in the Pharmacopeia was going on before 1961, when the FDA first required package inserts. Think of that for a moment. Until 20 years ago, the FDA did not exercise such control over prescription drug labeling. Now the package insert is so ubiquitous and its content so sacrosanct that we see physicians afraid to prescribe and pharmacists afraid to dispense other than in strict accordance with the package insert text. Even though FDA top brass regularly deny that the package insert is intended to control the practice of medicine, is it any wonder that FDA, organizationally, likes power and influence and wishes to extend it?

The Pharmacopeia continued its evolution toward provision of more professional practice information for the pharmacist; and for USP XIX in 1975 it was collected in the monographs under the title "dispensing information." By then, it had been expanded to include brief bits of advice for the pharmacist to consider providing to the patient.

Subsequently, in the 1975-1980 revision period just ended, the dispensing information was greatly enlarged. It ended up being published in 1980 in a separate book entitled *United States Pharmacopeia Dispensing Information*.

USP Dispensing Information System

USP Dispensing Information is an annual publication and the 1981 edition is as big as the whole USP 5 years ago. The first 2/3 of the *USP DI* book consists of dispensing guidelines for the professional, including in each monograph a section on patient counseling. The last 1/3 of the book, separated by a divider sheet and entitled *Advice for the Patient*, is lay language wording coinciding with the patient consultation guidelines.

Of course, a book of drug information must be kept up to date and *USP DI* is supplemented every two months. Supplements and wholly new text are consolidated in a new edition each year.

Only the most important changes and new drugs are covered in the bimonthly *USP DI Update*. To have full, up to date information, one must get a new *USP DI* each year. That is opposite to the situation with USP-NF, where purchase of a supplement each year will keep you up to date over a five-year period.

Pharmacists, physicians, nurses and other practitioners are encouraged to copy the lay language information and provide it in written form to their patients. The 1163-page *USP DI* book is a bit unwieldy for photocopying and the entire *Advice for the Patient* section has been published also as a separate book under the title *About Your Medicines*. It is expressly laid out, one monograph per page, for photocopying ease. We think this complete lay-language book will be especially useful for reference by patients while waiting in

doctor's offices and at pharmacy dispensing counters. By the time they see the doctor or pharmacist they may have read about other drugs they are taking and have some questions that might not otherwise come up.

The complete reference edition of *About Your Medicines* could be resold to patients, should they desire it. However, a shorter, less expensive edition more saleable at the prescription counter has also been published: *About Your Medicines, abridged consumer edition*. It contains about 400 drugs, including the top 200.

For many dispensers, however, it would be more expeditious and economical to be able to purchase leaflets of the individual drug monographs for the patient; four have been available thus far, for three antidiabetic drugs at the request of a state diabetes association, and one for the Thiazides. It appears also that pamphlets or booklets collecting the monographs for all of the drugs for certain types of diseases might be a useful and economical grouping of information, and we shall be looking into that.

To promote public awareness and concern for prescription drug information, USP is doing more than just providing pharmacists with a poster to display. Staying with the theme, "about your medicines," USP is distributing to newspapers nationwide a weekly column entitled "About Your Medicines" that they may print as a public service. In at least one state the pharmacists are so enthusiastic about the public relations value to Pharmacy that they have detailed association members to watch over each newspaper in the state.

To reach the well public that patronizes bookstores more than drug stores, we have contracted with Ballantine Books, a division of Random House, to provide the complete *About Your Medicines* text in a bookstore version, entitled *Physicians and Pharmacists Guide to Your Medicines*.

This has been a real boon to our efforts because Ballantine's promotion is based on USP people. Even though we are on a radio or TV talk show to promote Ballantine's bookstore edition, we always develop our theme that patients must talk to their physicians and pharmacists about their medicines. In going directly to the public in this way, USP is trying to help establish a climate of expectancy when the patient comes to the pharmacy — and a round-about pressure on reluctant pharmacists; for research has shown that the written word alone is no substitute for the human interaction of the health professional and the patient. The written word is better than nothing, but it is best as a competent tool in the counseling of a concerned health professional.

There's more. Having the current monograph text on floppy disks in our own in-house typesetting unit allows us to spin off, on demand, in a type style and layout to suit, any individual monograph as a leaflet or any collection of monographs as a pamphlet or booklet; for example, the leaflet on The Thiazides. A booklet containing all of the antihypertensives plus an educational section on high blood pressure was prepared in cooperation with the National High Blood Pressure Education Program, as a sample of what can be done. Consistent with our theme words, we have entitled it *About Your High Blood Pressure Medicines*.

You should understand from all this, then, that USP's

CELEBRATE WITH US

To commemorate its 100th anniversary celebration, the Maryland Pharmaceutical Association is issuing a special edition, custom designed apothecary jar. For a limited time only, members and friends are invited to purchase these deluxe containers in recognition of the association's first century of service.

Each glass jar is imprinted with a two-color reproduction of the Maryland Pharmacy banner and the words: "Honos, Firmus, Purissimus — Pharmacy, the Maryland Pharmaceutical Association — 1882-1982." The jars are suitable for home or office because of their wide variety of uses:



- * For countertops — to store herbs, food-stuffs
- * For desktops — to contain candy or dried fruit
- * For occasional tables — to preserve snacks or to use as a decorative accessory

No matter how you choose to use this handy apothecary jar, you will often welcome its attractive styling and utility. This jar is not available at any retail store! It has been designed especially for the association and is destined to become a collectors' item in the years ahead. Priced right for the value, you can save by ordering three or more:

\$12.00 — each
\$33.00 — for three — \$11.00 each
\$100.00 — for ten — \$10.00 each

Take advantage of this offer now. Simply complete the order form below and mail it to:

MhA
650 West Lombard Street
Baltimore, MD 21201

APOTHECARY JAR ORDER FORM

Name _____

Quantity _____

Address _____

Amount Enclosed \$ _____

DO NOT SEND CASH

Telephone _____

Return to: MPhA, 650 West Lombard Street, Baltimore, MD 21201

main contribution is to put the words together, to obtain the national consensus on what the patient should know and how that can best be said to him or her. You are saved the problem of worrying over the reliability of the information, of its general acceptance by the prescribing professions, of its meeting any national legal requirements. You can concentrate, then, on picking out what is most important for the patient you are talking to, considering his or her circumstances — and yours — at that moment.

I don't think there is any question about the USP Dispensing Information System being the most up to date, containing the most comprehensive information about any drug, and including more drugs than any other patient drug information system. But there are others; and for certain pharmacy practices and certain patients, they may be more useful than *USP DI*. At least a dozen other patient drug use information books are now available, some written by physicians, some by pharmacists, and some by lay writers. The American Society of Hospital Pharmacists has a medication teaching manual and some state pharmaceutical associations, notably Washington and Minnesota, have had patient drug use information projects for several years. Individual leaflets are available and stick-on labels are everywhere. Cash registers are decorated with health booklets.

Obviously, written drug use information provided directly to patients and provided as educational tools by practitioners is here. However, they are not used frequently and widely enough by health professionals voluntarily in caring for their patients.

FDA's Final PPI Regulation

On September 12, 1980 the U.S. Food and Drug Administration declared it was too little and too late. FDA published a final regulation in the *Federal Register* covering all drugs and provided general guidelines for the content of such information. The states rather than the federal government control pharmacy and medical practice, so FDA put its legal arm mainly on the manufacturers by reinterpreting the FD&C Act to declare that manufacturers are *not* exempt from providing patient labeling for prescription drugs after all. When the proposal was published some 15 months earlier, it was roundly condemned by industry, medicine, and pharmacy as unnecessary and exorbitantly expensive. Nevertheless, encouraged by consumer activists without and medical reformists within, FDA went ahead.

The FDA *patient* package insert (PPI) system is based on its professional package insert system and thus has the same deficiencies: the PPI is to be written by manufacturers within the general guidelines established by FDA, rather than by practitioners; and it is to be distributed by the manufacturers with the drug, or under separate cover, to the distributors or dispensers, skipping over the prescribers.

On the other hand, FDA will allow distributors and dispensers to throw away the manufacturers' PPI and issue their own provided, of course, that the distributor or dispenser meets the guidelines established by the FDA regulation.

Originally, FDA had proposed to require PPI for 50 to 75 drugs and classes of drugs, affecting thousands of commercial products. Concomitant with its final regulation, FDA proposed to start with only ten. Medical and pharmacy organizations claimed a great victory in getting FDA to

reduce from 50 to 75 down to 10. But what they overlooked is that the final regulation covered all drugs, not just 50 to 75. And in implementing 10 in the first three years, FDA was going as fast as it could ordinarily be expected to go anyhow.

FDA estimates that even those ten amount to 120,000,000 prescriptions per year, 16% of all prescriptions. The dispenser must dispense the PPI with each new prescription unless the prescriber orders him not to. Even then, the patient must get it if he asks for it. Furthermore, the manufacturer must make a Spanish-language PPI available to the dispenser, if requested.

Then came the Reagan administration, a new Secretary of HHS, and a new Commissioner of FDA. They have stayed the implementation. But make no mistake. They have not killed PPI. They have only stayed the first implementing regulations, Commissioner Hayes said, so that he may be certain that the proposed studies of PPI costs and benefits are adequate and that the studies include plausible alternative methods of providing patient drug use information, including, he specifically said, the USP DI reference books.

Effects of Mandatory PPI

Consider now some of the consequences of mandatory PPI's. The FDA regulation removed written drug use information, at least that which is dispensed with the drug, from the domain of patient education to the realm of legal labeling. All those education tools believed to best meet the needs of a particular patient population and proven in the marketplace are now hoist on the petard of the FDA general guidelines for content and presentation. For *USP DI*, this is no problem as the FDA general guidelines are practically the same as the parameters of the USP DI Advice for the Patient. In fact, FDA came so close that we delayed publication of our 1981 edition to make the necessary revisions so that we believe everything in it complies.

Other information services, however, are more brief and



William M. Heller, Ph.D.

we know from our own experiments that shorter versions of our own information are believed to be more useful in certain dispensing situations and for many patients. Since the final regulation covers all drugs and the general guidelines in that regulation would seem to govern voluntary PPI now for all drugs other than the ten, practically, at least, how could information providers expect pharmacists to take a chance on using voluntary PPI that do not comply with the general guidelines?

If the PPI are implemented, will the oral consultation by pharmacists fostered in recent years as a professional function be stifled? Will the pharmacist take the easy and apparently safe way out and just tell the patient to read the PPI? Since additional counseling costs time and time is money and since oral counseling might stray from the particular PPI for the drug brand dispensed and perhaps get the pharmacists in trouble thereby, I think the great majority of pharmacists will settle for meeting the legal obligation of simply dispensing a piece of paper.

Will that, however, really satisfy all legal obligations? Probably not. Once the manufacturer and dispenser have imposed upon them specifically the duty to warn the patient about the drug, they no longer have the prescriber to hide behind.

The brand substitution issue appears to be further clouded, too. Suppose the PPI of the prescribed brand warns about something that harms the patient, but the brand substituted by the pharmacist in strict accordance with the state substitution law does not carry that warning in its PPI. The pharmacist does everything in accordance with the laws, both PPI satisfy the FDA regulation, but the patient is not warned in the substituted PPI about the one thing that harmed him. Is it not likely that the lawyer for the plaintiff will zero in on that?

Since manufacturers will want to protect themselves by warning the patient about all possible problems, won't they soon load their PPI to the point where the patient is overloaded with information and finds no one with the courage to sort it out for him and place it in perspective? Is that really the patient outcome we want?

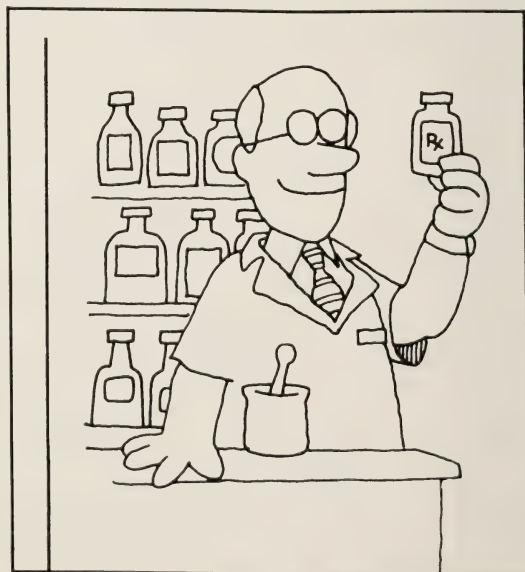
What about the logistics of providing these millions of pieces of paper? Although FDA says the mandatory ten are the subject of an experiment only, gearing up to provide PPI for 1/6 of the nation's prescriptions is a mighty costly experiment. Whatever systems are devised will be hard to alter. Regrettably, FDA went into this with no large accumulation of experience. No government health care agency such as the Veterans Administration or the Medicaid program had been persuaded that PPI were so beneficial that they should be provided routinely. No state agency had decreed that PPI be used routinely within a state. Thus the manufacturer/distributor/dispenser PPI distribution concept ordained by FDA presents many unknowns in terms of getting the right PPI to the right patient with the right drug. FDA's cost estimates were tripled from 6¢ to 18¢ per prescription between the time of their initial proposal and their final regulation and still have been challenged by all concerned.

For many dispensers it may be less costly to print their own or buy ten generic PPI that can be handled as an

integrated system than to handle the 300 to 400 brand PPI of all sizes and routes of acquisition, yet the manufacturers and distributors still have to provide the PPI, too — obviously a waste and expense. The manufacturer, of course, can be expected to raise his price to cover the number of PPI he supplies with each bottle. The dispenser generally will be able to pass that part of the cost along to the patient — except, of course, in government price-fixing programs which limit the amount they will allow the dispenser for the cost of the manufactured item. Such programs also limit the pharmacist to a standardized fee. Since such fees have rarely recognized pharmacists' patient education efforts in the past, it is not likely that they will raise fees readily now for patient information.

The distributor, the wholesaler, gets stuck, too. Where the manufacturer physically integrates the necessary number of PPI's into the drug product package, the wholesaler may incur no increased handling costs. But think of the wholesalers' problems if the manufacturers of a couple of hundred brands take advantage of the option to supply the PPI separately from the drug package. The wholesaler not only has to maintain all that additional storage but has to pick both the drug package and the required number of PPI for it every time he fills an order. There is no provision for paying him for these extra costs. In her press conference announcing the institution of the ten mandatory PPI, Health and Human Services Secretary Harris, of the Carter Administration, said she hoped that the various parties in the drug supply system would absorb their respective shares of the cost. Since only the government seems to be able to survive year after year in the red, that attitude is naive to say the least. Ultimately, somehow, the patient is going to pay. It's too bad that those who don't need it would have to pay, too — not only for the ones they get but for the duplicates discarded along the way.

A couple of years ago FDA surveyed various groups concerning the priorities it should give to its various prog-



rams and projects. Except for consumer activists, all those surveyed put PPI near the bottom; even FDA's own employees were relatively unenthusiastic. Apparently, only a small group within the agency has been pushing the PPI project. If you are for mandatory PPI, you can be proud to see that persistency can pay off even for a minority faced with adversity. If you are against mandatory PPI, you can appreciate that even a small group can unleash a monster that may well have more widespread public, professional, legal, and logistical effects and costs than any program FDA will embark upon in our lifetimes.

Monsters can't be contained by half-hearted actions. Freedom of speech in the drug information field cannot be regained from federal usurpation unless the nongovernmental forces mute their self interests and band together to produce a workable system for voluntary PPI before the three-year trial is up. If manufacturers, distributors, and dispensers don't put an alternative system in place and obviously working satisfactorily, the mandatory PPI monster will move on rapidly to gobble up more and more drugs.

Pharmacists have been doing a lot of talking about patient consultation, but they haven't been doing it. It's time to stop talking among ourselves and start saying something worthwhile to patients.

The lack of an organized drug information base is no longer an excuse for not doing so. *USP DI* gives you the tools.

Advantages Of PPI to FDA

But we're still faced with FDA's PPI regulation. It is final. Although they can stay the implementation regulations for awhile, they can't do that indefinitely. They've already got a consumerist law suit against them.

Look at it from FDA's viewpoint and you can understand why they've continued with their PPI proposal.

- The consumerist spokesmen are all for it.
- It gives the public something positive that they haven't had before — and in view of all the consumerist programs the Reagan Administration is chopping out, they need any bones they can toss to the consumerists.
- It costs the government very little — just the salaries of a few people to answer the mail. They have already announced that they would not review labeling for approval; each label provider is on his own, subject to the PPI regulation. Even creation of an enforcement operation to make sure pharmacists give out the PPI would run only a few million dollars a year.
- The actual costs to the consumer are hidden. The price of the prescription goes up, but the public will blame the pharmacist or the manufacturer.
- It gives FDA a whole new dimension of control over each manufacturer. The PPI would not be limited by whether a drug is a new drug or an old drug, whether it is pre-'38, DESI, post '62, NDA, ANDA, originator or me-too. It would give FDA a handle over every brand. It doesn't take much imagination to turn a handle on PPI into a club on other matters that now squirm away through what FDA regulators may feel are undesirable legal loopholes.
- PMA and some manufacturers favor PPI; it gets their name and message all the way to the consumer and the

manufacturer will be able to charge for it. Good. FDA is glad to have a bone to throw to manufacturers, too.

- Some manufacturers are against PPI. Fine. Consumerists would be suspicious if all manufacturers were for PPI.
- AMA is against PPI. Good. After all, FDA and the consumerists say that doctor-failure is the main reason PPI are needed.
- APhA is against PPI. So are NARD and NACDS. FDA can say, Who cares? Reputedly, pharmacy has little political clout. The pharmacy organizations seem to unite only in opposition to something; they rarely agree on any positive alternative.

Does that litany of views from the FDA side of the PPI issue convince you that FDA is going to kill the PPI program if we in Pharmacy just keep hollering against it?

Alternatives to FDA-Mandated PPI

I think we must offer FDA an attractive alternative if we are to alter their course. We must give them something they do not get with their own proposal if we expect them to give up something.

What have we got? What have Pharmacy and Medicine and the Manufacturers who oppose PPI got?

One thing I can see is the USP DI system. It would give FDA, immediately, PPI for practically all drugs; PPI that meet the general requirements in their final regulation. In recognizing *USP DI*, FDA would be giving up control over each manufacturer. So it's a trade-off. Is dealing with one organization and getting all drugs covered now more attractive than dealing with thousands of firms and the leverage over other matters that control of PPI would give them?

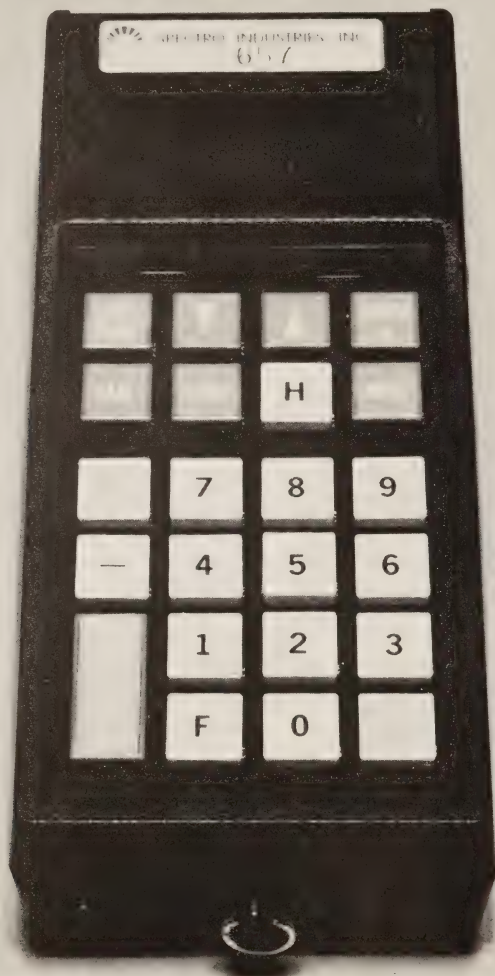
But USP simply having the information compiled is not enough. FDA would have to have assurance that it is available to the patient. So another thing Pharmacy can give FDA is cooperation. By making PPI mandatory, FDA would overcome lack of cooperation. What assurance can Pharmacy, or Medicine, give that the USP DI information will be available to patients who need it?

There's where we are stuck right now. All pharmacies do not have the USP DI book or the *About Your Medicines* book. Those that do are not all using it regularly for patient education. If pharmacies had it and pharmacists used it, FDA could hardly be so uncooperative as to not give the nongovernmental effort a fair test.

To get unstuck, we need pharmacy leaders to get together and offer FDA assurance of a positive alternative. One major organization leader told me that his organization would make sure that *About Your Medicines* would be available in every pharmacy if FDA would then hold up on requiring PPI. One manufacturing leader has told me that in one day of phone calling he could collect enough money to send *About Your Medicines* to every pharmacy at no charge — if national pharmacy organization leaders advocated it and worked to gain cooperation of pharmacists in using it.

Perhaps those national pharmacy organization leaders can be encouraged by an appropriate resolution from the Maryland Society of Hospital Pharmacists and the Maryland Pharmaceutical Association to stop talking negatively and start doing something positively to get the PPI situation resolved to the benefit of pharmacy and the government, and medicine and industry, and especially the patient.

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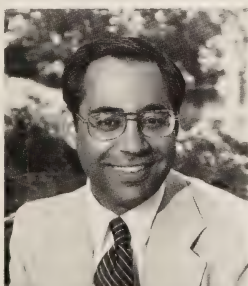
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Our best friends are our severest critics and our greatest assets.

Meet our 1981 Pharmacy Consultant Panel.



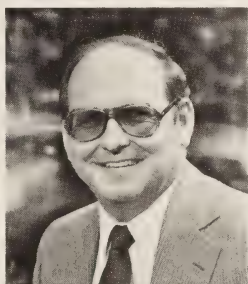
H. Joseph Schutte, R.Ph.
Community Pharmacist
Louisville, Kentucky



Louis M. Sesti, R.Ph.
Executive Director
Michigan Pharmacists Association
Lansing, Michigan



Milton H. Miller, R.Ph.
President, Petty Drug Company, Inc.
Little Rock, Arkansas



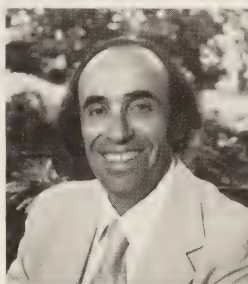
Gary Thudium, R.Ph.
Community Pharmacist
Vinton, Iowa



Martin Lambert, Ph.D., R.Ph.
Community Pharmacist
Knoxville, Tennessee



Marianne Ivey, R.Ph.
Clinical Pharmacist
University of Washington Hospitals
Seattle, Washington



Harold H. Wolf, Ph.D., R.Ph.
Dean, College of Pharmacy
University of Utah
Salt Lake City, Utah



Paul Burkhardt, R.Ph.
Director of Pharmacy
University of Maryland Hospital
Baltimore, Maryland



Harland W. Henry, R.Ph.
Director of Pharmacy
Memorial Hospital System
Houston, Texas



Stephen D. Roath, R.Ph.
Vice President, Director of
Professional Affairs
Longs Drug Stores, Inc.
Walnut Creek, California

sional and other pertinent matters are invaluable.

Their advice and counsel helps us serve you better in the expanding role of pharmacy

No diplomatic double talk. We need the advice of pharmacists in order to do a better job for pharmacists. The bad news and the good. That's what the ten members of our 1981 Pharmacy Consultant Panel provide. Their views on profes-

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Your insulin patients vary greatly in their specific requirements for insulin. Not only is *daily dosage* a factor in achieving satisfactory control, but duration of insulin action is also. The Lilly line of insulin products is so complete that it can meet the needs of virtually all insulin-dependent diabetics.

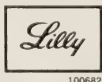
For most diabetics . . . Iletin I

All Lilly insulin preparations bearing the trademark Iletin I contain a mixture of beef and pork insulin. The majority of diabetics manage their diabetes most effectively by using one or more of the many forms of Lilly insulin that are currently available. In 1980, Lilly improved the purity of its insulin products significantly, so that all forms now contain less than 50 parts per million of proinsulin (proinsulin content is the standard measure of insulin purity). The "single-peak" Iletin sold between 1972 and 1980 had a proinsulin content of <3000 parts per million.

For diabetics with special needs . . . Iletin II

Iletin II products are insulins derived from only one animal source—either beef or pork. The use of Iletin II, Pork, or Iletin II, Beef, is generally reserved for patients who demonstrate a clinical need for single-species insulin. Iletin II products are in a new class, recognized as purified insulins. All purified insulins contain <10 parts per million of proinsulin.

ILETIN® I
beef-pork insulin



ILETIN® II
purified pork insulin
purified beef insulin

insulins that maximize control

Additional information available
to the profession on request.



Dear Mr. Banta:

I appreciate very much the kindness of the Maryland Pharmaceutical Association in giving me the plaque that arrived several days ago.

I shall hang it on my office wall and it will remind me of the many pleasant meetings that I enjoyed with your organization at Buena Vista and Ocean City.

With all best wishes and many thanks, I remain

Sincerely yours,

John C. Krantz, Jr., Ph.D.

Honorary President

Dear Dave,

I wanted to alert you to the following changes for our company.

Sales & Discount Policy changes effective July 1, 1981 — *Pharmaceutical Products — Wholesale Only*

As of the above date, a wholesaler only distribution policy is in effect for all Merrell Dow pharmaceutical products. Please contact the wholesaler of your choice immediately to arrange distribution.

Dial a Duck In D.C. (202)

Call 652-1088, and you'll hear the Audubon National Society's report on sightings of rare birds around D.C. Or Dial-a-Regulation at 523-5022 and find out how your tax dollars are being spent, with updates from the Federal Register.

There are dozens of recorded messages just a phone call away with information on anything from stocks to tooth care to consumer tips. Here are some more:

Dial Congress: Both Republicans and Democrats will give you their version's of what's happening in the House and Senate. House: 225-7400 (Democrats), 225-7430 (Republicans). Senate: 224-8541 (Democrats), 224-8601 (Republicans).

Dial-a-Dentist: 347-7878: Helpful tips on tooth care, from the Metro Area Dental Health Council.

Dial Dow Jones: 212/999-4141 (New York): The latest stock market index is updated hourly.

Dial-a-Joke: 212/999-3838 (New York): It's good for a laugh.

Dial-a-Microsecond: 254-4950: This is the *real* time recording — from the U.S. Naval Observatory's Master Clock, accurate to within a microsecond.

Dial-a-Museum: 357-2020: Hear the latest on activities at the Smithsonian.

Dial-a-Prayer: 532-3033, 229-2022, 971-5555: It might help you on bill-paying days.

Otc Products — Direct Purchase

Should you desire to purchase Merrell Dow OTC products on a direct basis, please contact your Merrell Dow Representative. The enclosed OTC Products Direct Price List provides complete information on direct purchasing terms. *Outdated & Retail Damaged Product Allowance*

Both the pharmaceutical and OTC products groups of Merrell Dow have adopted a 1.25% *Outdated and Retail Damaged Product Allowance* as an innovative approach to handling such returns. This allowance is paid to all wholesalers to compensate them for handling your outdated and retail damaged Merrell Dow products.

Note: A grace period through September 30, 1981 is in effect during which outdated and retail damaged products of the former Merrell-National Laboratories can be returned under the former Merrell-National returns goods policy. Former Dow Pharmaceutical products have in the past, and will continue under the 1.25% policy mentioned above.

Pricing

Pharmaceutical Products — Since you will now purchase Merrell Dow Pharmaceutical products from your wholesaler, he can advise you of the new prices which become effective July 1, 1981.

OTC Products — The enclosed OTC Products Direct Price List provides complete information on OTC increases effective July 1, 1981.

Sincerely,

Monti Montecelli

Merrell-Dow Pharmaceuticals

Oriental Odyssey

More and more members are requesting the Orient for a vacation destination every year. This year the Maryland Pharmaceutical Association is happy to oblige with a 16-day, 14-night extravaganza . . . the Oriental Odyssey, leaving on October 30, 1981 for Tokyo, Kyoto, Taipei, Hong Kong and Bangkok featuring an optional tour of mysterious Mainland China.

Thanks to the efforts of our travel department, members, and their families and friends will be able to see the Orient at the incredible money-saving price of as low as \$1999 plus 15% tax and services. As you'd expect, our travel people have seen to it that everything is planned for your convenience.

All air travel will be aboard scheduled Japan Airlines' wide-bodied jets . . . hotels are deluxe . . . we've included 14 American breakfasts, 9 Oriental dinners, parties, tours and more . . . and, of course, all those little details (transfers, tips for bellmen, chambermaids, etc.) have been taken care of to make the vacation completely hassle-free.

This exclusive trip has been arranged for us by Trans National Travel, the nation's leading tour operator for groups like ours. Trans National works hard so you can enjoy the wonders of Tokyo, Kyoto, Taipei, Hong Kong and Bangkok.

Reservations for the Maryland Pharmaceutical Association's deluxe Oriental Odyssey will be accepted on a first-come, first-served basis. Look for full details in your mailbox soon, or call (301) 486-2262 or (301) 569-9177 for more information.

Before we start to discuss the subject, I think we should define four terms. They are: Degree, Designation, Title, and Doctor.

A *degree* is something a college or university grants for recognition of completion of course of study. For example: Bachelor of Science is a degree which only a college or university can grant. Doctor of Medicine, Doctor of Law or Master of Science would be other examples.

Designation consists of the letters behind someone's name that let the public know legitimately who they are. The classic example would be: M.D., which is a designation, not a degree. M.D. of course designates Doctor of Medicine. It is often confused among people who tend to see the M.D. as a degree.

A *title* is an appellation of dignity, distinction, or preeminence given to persons.

Doctor is the latin term for teacher, a learned man. It is an advanced academic title; hence, one on whom this title has been conferred by a university or college. A doctorate degree may be merely honorary. "Doctor" has many other meanings and is not limited by use exclusively to the title conferred by a university or college.

The professional designation study committee was even-ly split on which designation to recommend to the convention. The one thing everyone agreed upon was that the designation R.Ph. (Registered Pharmacist) must be changed.

The State of Maryland has defined three levels of occupational recognition: Licensing, Certification, and Registration. Licensing is the highest recognition. Registration is the lowest. Since pharmacists are licensed and not registered, the designation R.Ph., which stands for Registered Pharmacist, is totally inappropriate.

Now since the consensus of opinion was that R.Ph. must go, we were left with the task of choosing a new designation for the profession. Two possible designations were proposed:

1. Doctor of Pharmacy — Abbreviated: P.D.
2. Pharmacist — Not Abbreviated.

I would like to present my reasons for supporting the P.D. designation (Doctor of Pharmacy) as the uniform designation for all pharmacists. I would like to take the resolution point by point and explain the purpose behind each one.

1. MPhA can determine the professional designation of pharmacist, the state laws have been searched to make sure there is no prohibition against pharmacists using the title doctor. The Association adopted the R.Ph. even though it was a misnomer, at that time. The school of pharmacy never granted the R.Ph. The Association itself choose to utilize the R.Ph., so we certainly have the legal right and responsibility to the practicing pharmacist to adopt a P.D. designation when it is obviously more appropriate.

2. In the evolution of the practice of medicine, educational requirements and standards became more strict. However, the medical profession at no time tried to identify the current practioners, or those with a lesser technical education, with any negative connotations. They were dedicated to keeping the profession united in designation and titles

even though the degrees and academic requirements were increasing. Optometry is an excellent example. In the late 1930's most optometry schools were granting a four-year B.S. degree. The profession of optometry, through long-range planning, decided where they wanted to go. They decided they wanted all their practioners to have a degree, a designation, and a title which carried the highest professional respect. In 1941, the optometric profession chose the designation O.D. to be utilized by all optometrists. The designation, O.D., carried with it the title, "Doctor of Optometry". When optometry went to a five-year college degree, a mid-point in their professional evolution, they enrolled their students in graduate school during the fifth year of the five-year course and they all received a M.S. They still utilized the same O.D. designation and the title "Doctor of Optometry". When optometry reached the ultimate goal, and granted a six-year doctor of optometry degree, they still utilized the same O.D. designation and the title Doctor of Optometry. Then they let their education requirements evolve without any disruption or differentiation between optometric practioners by titles or lack of titles. None of the health care professionals evolved higher academic requirements and new titles and degrees and ignored the existing practioners of that profession.

Why the "P.D."

Lee
President of
Pharma

This speech was delivered
land Pharmaceutical Assoc
Committee on Professional
Shortly after this presentati
adopt the professional Desig
the use of all Maryland Pha

The pharmacy educators apparently have decided to ignore our current practitioners. They have not suggested an alternative to having some pharmacists have an entry-level degree of Doctor of Pharmacy (Pharm.D.) and others with five-year B.S. degrees.

The only legitimate alternative is to unify the practice of pharmacy with one single recognizable designation and the title (Doctor of Pharmacy) for all pharmacists.

3. M.D. for physician
- D.D.S. for dentists
- O.D. for optometrists
- D.V.M. for veterinarians
- P.D. for pharmacists.

The P.D. designation will be used for all pharmacists, regardless of their level of education just as has been done with all other professions. Advanced professional degrees such as Pharm.D. and advanced research degrees such as M.S. and Ph.D. will be used after the P.D. designation.

James Smith, P.D.

James Smith, P.D., Ph.D., etc.

The use of the P.D. should in no way detract from the

prestige of the Pharm.D. degree that some pharmacists have already earned.

4. P.D. is a designation of the future. The APhA and the ASHP positions supporting the concept of a single doctor of pharmacy degree as the basic pre-requisite for professional pharmacy practice, along with the increasing number of schools that have announced the change to only the Pharm.D. program (17 to date) and the growing number of schools that are increasing the percentage of Pharm.D.'s in relation to B.S. graduates (University of Maryland included), dramatically emphasize the trend toward fewer and fewer B.S. graduates and more and more Pharm.D.'s and more and more pharmacy school trained two-year pharmacy technicians. The lack of a Doctor title will hinder B.S. pharmacists when others are entering the profession with a Doctor title

I feel the shift is on to a doctorate entry level degree for the entire profession and the victims of this transition period will be the B.S. graduates. No other professions have allowed the educators to upgrade the educational standards and not grandfather the existing practitioners. It is unthinkable that our school is training two levels of pharmacists, who will have different degrees, different titles, and both practice under exactly the same license with exactly the same powers and limitations and take the exact same exam for licensure. licensure.

If we do not grandfather the doctor title to all pharmacists, we would be creating a second-class of pharmacists who will be discriminated against by the difference in titles.

The schools have said that they would try and make it easier for us to come back to school and earn a Pharm.D. To ask pharmacists to return to school to get a Pharm.D. would be economically unfeasible and create family hardships. Other professions did not require the practitioners to return to school.

Our profession must do as other professions have done and adopt a uniform designation that accurately identifies its practitioner and carries with that designation the title of Doctor.

Some may accuse the pharmacists of just wanting more prestige or even being on an ego trip. Let them say what they want. We want and need uniformity in professional titles as granted to all other health care professionals. Anyone who says there is nothing in a title doesn't understand human nature or already has a title. All other major health professionals use the title Doctor. This title enhances professionalism and places the pharmacist on equal footing with other health care professionals who currently have the title.

5. In recent years pharmacists have begun to move away from the traditional product orientated practice of pharmacy to other more clinical aspects of the profession; such as, monitoring drug therapy, patient compliance, reviewing patient profiles for allergies and drug interactions, manning the poison control center, new roles in management of high-blood pressure and early diagnosis of disease, and many other clinical areas never before attempted.

6. This is a local phenomenon for the Baltimore area mainly, and not all areas of the state, but a large segment of the Maryland population already, and have for years, addressed the pharmacist as Doctor.

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PHARMACY SUMMIT CONFERENCE



Pictured during the regular meeting of the Joint Commission of Pharmacy Practitioners (JCPP) in Washington, D.C. are the following pharmacy leaders: (left to right) R. Timothy Webster, Executive Director, ASCP Milton S. Moskowitz, President, ASCP Marianne Ivey, President, ASHP Robert B. Greenberg, Legal Counsel, ASHP John M. Rector, Director of Government Affairs, NARD D.C. Huffman, Jr., Executive Vice President, ACA William E. Woods, Executive Vice President, NARD Thomas K. Denson, President, ACA David A. Zilz, Immediate Past President, ASHP Joseph A. Oddis, Executive Vice President, Ashp Robert J. Bolger, President, NACDS

The Commission reviewed numerous matters of special interest to pharmacy practitioners, including recommendations on expiration dates for pharmaceutical products, Doctor of Pharmacy (P.D.) developments, and the lowa capitation pharmacy reimbursement research. Regulatory and legislative items reviewed included PPI's, the MAC program, select Medicaid regulations, patent and estate tax reform and pharmacy crime legislation. The status of Medicaid freedom of choice for pharmaceutical services understandably dominated the JCPP deliberations. JCPP members are taking several actions individually and collectively aimed at the retention of freedom of choice. The JCPP organizations represent 90 percent of the nations practicing pharmacists.

Richard R. Ashbaugh has been appointed Chief Pharmacy Officer of the Public Health Service by Assistant Secretary for Health Edward N. Brandt, Jr., M.D.

Mr. Ashbaugh will represent the Public Health Service in matters dealing with pharmacy and maintain liaison with professional pharmacy groups. He'll also be responsible for manpower development, recruitment, training, and career counseling in the pharmacy discipline. His appointment carries with it the rank of Assistant Surgeon General.

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The Founding of MSHP

by
Norman Pelissier

On the evening of March 25, 1944 a group of fifteen hospital pharmacists met at the Maryland General Hospital in Baltimore. The group's first order of business was to decide its geographic scope and what name it would adopt. Three possibilities were considered: 1) creation of a local group for hospital pharmacists in Baltimore, 2) creation of a state group of hospital pharmacists, and 3) creation of a combined Maryland-District of Columbia group of hospital pharmacists. Following some discussion a vote was taken and the consensus was that the group would represent the state hospital pharmacists and thus the name "The Maryland Association of Hospital Pharmacists" was adopted by the group.

So reported secretary-treasurer Harriett R. Noel in the first recorded minutes of this group. Also at that first meeting, a Constitution and Bylaws was adopted and officers of the Association for the 1944-1945 year were elected.

President: Mr. Gordon A. Mouat
Maryland General Hospital¹
Vice President: Mr. Anthony Mentis
Union Memorial Hospital
Secretary-Treasurer: Miss Harriet R. Noel
University of Maryland Hospital
Executive Committee: Mr. Robert Fuqua
Johns Hopkins Hospital
Miss Clara Herkowitz
Baltimore City Hospital
Mr. Reuben Alperstein
Sinai Hospital

A second meeting was held at Sinai Hospital on April 29. The topic of discussion centered on the procurement of certain scarce chemicals (due to the War) such as triethanolamine, glyceryl mono-stearate, menthol, thymol, ethyl alcohol and isopropyl alcohol. This meeting, like those held the first several years of the Association's existence, was held on a Saturday night. Meetings generally began at 7:30 p.m. and often did not end until after 11:00 p.m. Attendance normally consisted of ten to twenty members.

The Association's third meeting was held on July 29 at the Women's Hospital. This hospital located at Lafayette and John Streets was to become the Greater Baltimore Medical Center in 1964. The group voted to contact all

hospital superintendents throughout Maryland by letter asking them whether or not the people employed by them to handle drugs were pharmacists. The fourth meeting, held on November 18, was held in the amphitheatre of the University of Maryland Hospital. This was the first meeting at which an outside speaker was invited to talk to the group. Nineteen members and 23 invited guests were present. The speaker was Dr. Russell Nelson of the Johns Hopkins Hospital who spoke on "The Newer Aspects of Penicillin". Dr. Nelson mentioned a newer discovery, streptomycin, which showed promise of being effective against gram-negative organisms. A program committee was appointed consisting of Mrs. Angela Allen, Mr. Alexander O'Grinz, and Mr. Milton Skolaut.²

The fifth meeting of the Association was held in Hurd Hall of the Johns Hopkins Hospital in January of 1945. Dr. John C. Krantz, Jr., Professor of Pharmacology at the University of Maryland School of Medicine, spoke on "The Newer Developments in Volatile Anesthetics". He discussed the two anesthetics in common use at that time, ether and cyclopropane. Mr. Alperstein reported on correspondence with the American Society of Hospital Pharmacists,³ inquiring whether this recently formed group was affiliated with the American Pharmaceutical Association or the American Hospital Association. The response from ASHP indicated that it was affiliated with the American Pharmaceutical Association.

On March 24, 1945 the Maryland Association of Hospital Pharmacists observed its first anniversary in the Board Room of the Union Memorial Hospital. Nominations were presented for candidates for office for the following year. The results of a mail ballot election were announced at the Church Home and Hospital on April 28.

President: Mr. Anthony Mentis
Union Memorial Hospital
Vice President: Mr. Milton Skolaut
University of Maryland Hospital
Secretary-Treasurer: Mr. Frank Steele
Johns Hopkins Hospital

The following meeting was held on June 2, 1945 in the office of the Superintendent of the West Baltimore General Hospital.⁴ Miss Blanche Leites was appointed secre-

tary-treasurer replacing Mr. Steele. On October 13, 1945 a meeting was held at the Fort Howard Hospital. An application blank and invitation were received for the Maryland Association of Hospital Pharmacists to join the Maryland-D.C. Hospital Association upon payment of \$47.50 dues. The group decided to postpone this decision.

From the secretary-treasurer's report of January, 1946

Balance on hand January, 1946: Bank	\$65.55
Cash	9.70
	<hr/>
	\$75.25

January 9, 1946 expenditures:

Dinner for 5 at Munder's ⁵	\$10.00
Flowers	1.50
Cigarettes	4.29
Tip for waitress	<u>3.00</u>
	\$18.79

Balance: \$56.46

President Skolaut presided at the meeting held on February 9, 1946 at Women's Hospital. A discussion was held on whether all members leaving the organization would become honorary members. It was reported that new regulations required separate fire-proof storage facilities for alcohol.

New officers were elected at the March 9, 1946 meeting held at the South Baltimore General Hospital:

<i>President:</i>	Miss Blanche Leites Women's Hospital
<i>Vice President:</i>	Dr. William Arthur Purdum Johns Hopkins Hospital
<i>Secretary:</i>	Mrs. Angela Allen South Baltimore General Hospital

The next meeting was held on May 11, 1946 at the Memorial Hospital in Cumberland. A discussion was held as to the need of a pharmacist at Franklin Square Hospital. On June 16, the Association met at Mercy Hospital. Captain Monroe Romansky of Walter Reed Hospital spoke on "Penicillin". At the September 21 meeting held at Baltimore City Hospital, Dr. Purdum reported on his attendance at the ASHP Institute held in Ann Arbor, Michigan. On January 11, 1947 the MAHP met at the West Baltimore General Hospital. A film on "The Use of Amino Acids in Surgery" was shown. At the meeting held on February 24, 1947 at the Johns Hopkins Hospital, nominations were presented for new officers. The results of the mail ballot were reported at the April 4, 1947 meeting at the Union Memorial Hospital.

<i>President:</i>	Dr. W. Arthur Purdum Johns Hopkins Hospital
<i>Vice President:</i>	Miss Blanche Leites Women's Hospital
<i>Secretary-Treasurer:</i>	Angela Allen South Baltimore General Hospital

Dr. Purdum suggested that the Association form a journal club "to make reports at meetings on any articles that would have been read that would be of interest to other members". At the December 13, 1947 meeting held at Women's Hospital, Dr. Purdum was congratulated on being elected President of the ASHP. The question of ASHP affiliation was discussed at this meeting but no conclusion could be reached. It wasn't until March 5, 1949 that an amendment was passed to limit membership to active and associate members in order that the Association could become affiliated with the ASHP. Apparently, the MAHP became affiliated with the ASHP that year.

New meeting sites of the Association included the Nurses Home of St. Joseph Hospital, March 5, 1949; Franklin Square Hospital, January 21, 1950; the U.S. Marine Hospital (which later became the USPHS Hospital), May 26, 1951; and the Medical Supply Depot, USPHS, Perry Point, Maryland, December 10, 1952. Herbert Flack and several of his pharmacy interns from the Jefferson Medical College were guests at this latter meeting.

The MAHP met at the Kelly Memorial Building on February 18, 1953. Greetings were extended by Mr. Joseph Cohen, Executive Secretary of the Maryland Pharmaceutical Association. Dean Noel Foss addressed the Association at a meeting held on April 25, 1953 at the University of Maryland School of Pharmacy.⁶ Mr. Richard Crane⁷ of Armour Laboratories presented a film on the product Tryp-tar.

The new officers installed in the Coach Room of the Park Plaza Hotel on August 5, 1953, were: President Steve Ruth, Vice President Elizabeth Cassidy, Secretary-Treasurer Mary Ann Coleman and Corresponding Secretary Dudley Demarest.⁸ In 1956 the secretary-treasurer position was made into two separate positions and present member Mary Connelly⁹ began 12 years of continuous service first as secretary of the Association from 1956 to 1960 and as secretary-treasurer from 1960 to 1967. In 1967 she was re-elected as secretary and the treasurer position has been a separate position since that time.

Miss Ursula Heyer¹⁰ was guest speaker at the January 1958 meeting held at the Johns Hopkins Hospital. Miss Heyer's topic was entitled "Drugs of Colonial Virginia". Dr. Robert Lawson, Director of Pharmacy at the University of Maryland Hospital, spoke on parenteral solutions at the May 21, 1958 meeting held at the USPHS Hospital.

Mr. Alexander Ogrinz¹¹ was guest speaker at the April 16, 1959 meeting of the MAHP held at the Park Plaza Hotel. He spoke on the proposed pharmacy legislation presented to the Maryland Legislature. Mr. Vernon Trygstad, president-elect of the ASHP was present.

Internship requirements for pharmacist registration were discussed at the March 17, 1960 meeting of the MAHP held at the Johns Hopkins Hospital. President Statler reported on his meeting with Mr. Francis Ballassone,¹² secretary of the Maryland Board of Pharmacy. Prior to registration in Maryland, a pharmacist must work in a pharmacy for one year, four months of which must occur after graduation. A maximum of six months credit can be received for working in a hospital pharmacy. It was a unanimous decision on the part of the members present to press for full credit for

hospital pharmacy experience.

Mr. Neil Davis, Director of Pharmacy Services at the Jefferson Medical College, Philadelphia, spoke on "A Pharmacy and Nursing Committee" at the June 15, 1961 meeting of the MAHP held in the Gordon Wilson Hall, University Hospital. This was a joint meeting held with the Maryland League for Nursing.

During the 1960's there was a close association between the Maryland group and the District of Columbia hospital pharmacist's group. Installation of officers was generally a joint affair held at the Walter Reed Army Hospital and a number of meetings were held at the National Institutes of Health and the Bethesda Naval Hospital. The Association had just over 100 members in 1962. This included 65 active members, 34 associate members and 2 interns. Attendance at meetings, however, was generally quite low.

The Maryland Association of Hospital Pharmacists was to undergo a lot of changes during the 1960's. In 1966 the Association's name was changed to the Maryland Society of Hospital Pharmacists and the first annual Hospital Pharmacy Seminar was held that year in Ocean City with President Sydney Burgee in office. Attendance at meetings began to increase. The Society became officially incorporated in 1969. At the February 12, 1970 meeting, President Samuel Lichter made note of the incorporation and announced that the Society's bylaws would be revised in order to apply for tax-exempt status. The Society's first Newsletter, edited by Norm Pelissier, made its appearance in October, 1969. This was also the year that the Society approved its first dues increase (from \$3.00 to \$10.00).¹³ And in 1968, work began on what was to become the Society's longest undertaking, the "Suggested Principles and Guidelines for Pharmacy Services in Hospitals."

(to be continued)

FOOTNOTES

1. Mr. Mouat, who died on November 25, 1980, was a charter member of the American Society of Hospital Pharmacists (1942). He was awarded posthumously the W. Arthur Purdum Award of the Maryland Society of Hospital Pharmacists in June, 1981.
2. Mr. Skolaut, president of ASHP in 1963-1964, was an active member until November, 1969 when he left his position as Director of Pharmacy at the N.I.H. to assume the same position at Duke University Medical Center.
3. The American Society of Hospital Pharmacists was founded in 1942 and incorporated in 1955. In 1960, the ASHP established its offices in the headquarters building of the American Pharmaceutical Association. In 1966 the ASHP moved to its own headquarters where it is presently located in Washington.
4. West Baltimore General Hospital became Lutheran Hospital around 1950.
5. Farewell dinner for Mr. Fuqua and Mr. Mentis. (Munder's was formerly located at 4536 Harford Road.) At this time it was unanimously voted that Mr. Fuqua, Mr. Mentis, and Mr. Mouat be made honorary members. Mr. Skolaut assumed the presidency.
6. Dr. Foss served as Dean of the School of Pharmacy until 1968 when he was replaced by Dr. William J. Kinnard, Jr.
7. Mr. Crane later worked for Geigy Laboratories for many years before joining the State Division of Drug Control. He retains current membership in the MSHP.
8. Present active member and Director of Pharmacy at North Arundel General Hospital.
9. Present active member and Director of Pharmacy at Mercy Hospital.
10. Present active member and Director of Pharmacy at the Greater Baltimore Medical Center. Miss Heyer is also a past president of the National Catholic Pharmacists Guild, and is active in the International Federation of Catholic Pharmacists.
11. Presently with the Division of Drug Control and an active member of MSHP. Mr. O'Grinz was a partner of Gordon Mouat for many years while they operated the Burriss and Kemp Pharmacy on Greenmount Avenue in Baltimore.
12. Mr. Ballassone passed away on January 2, 1972. At the time of his death he was both Secretary of the Maryland Board of Pharmacy and Chief, Division of Drug Control for the State of Maryland.
13. Dues for active members were enacted on the following dates: March 1944, \$3.00; January 1970, \$10.00; January, 1976, \$15.00; January 1980, \$25.00.

Bits and Pieces

Pharmacist *Morton Scherr* of Marlyn Pharmacy was nominated to receive the Baltimore County award for a "small retail service business making a significant contribution to the community." — Pharmacist *Julian Miden* of Beeli's Pharmacy received the Mayor's Energy Conservation Recognition Certificate from Baltimore Mayor *William Donald Schaefer*. — *Morris L. Cooper*, Curator of the B. Olive Cole Museum in the Kelly Memorial Building, has been asked by the New Jersey Pharmaceutical Association to assist them in the creation of a Pharmacy Museum. He will be working with *Michael Robert Harris* from the National Museum of History and Technology in examining and classifying articles. —

The *Pharmaceutical Services Foundation* (PSF) announces a fee increase effective August 1, 1981. Member Pharmacies with profiles will receive \$3.35. Non-member pharmacies with profiles and member pharmacies without profiles will receive \$3.00. Non member pharmacies without profiles will receive \$2.75. PSF is now computerized and they require both the NDC number and the drug name. — The *Board of Pharmacy* has adopted the following regulation which took effect August 3, 1981: "A pharmacist may not return to his drug stock and offer for sale any prescribed drugs which have been previously sold and have left his possession, except as provided below. A pharmacist may accept return of prop-

erly labeled and properly sealed manufacturers package or individual unit does of drug which he ascertains to have been handled in a manner which preserves the strength, quality, purity and identity of the drug during any interim period between the sale of the drug and any return to the pharmacy."

Past President Dies

Albin A. Hayman, Past President of the M.Ph.A., died at the age of 85. A retired pharmacist from Salisbury, he had also served as a City Council President. Dr. Hayman was President of the M.Ph.A. in 1946.

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As part of SK&F's pharmacy services, there are several programs available that can help pharmacists with day-to-day managerial problems like those mentioned by Mr. Shelton.

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

METRONIDAZOLE:

An intravenous form of metronidazole (Flagyl) has been introduced for treatment of anaerobic infections including *Bacteriodes fragilis* resistant to clindamycin (Cleocin), chloramphenicol (Chloromycetin), and penicillin. The most common side effects include gastrointestinal discomfort, rash, headache and dizziness. The drug will be reserved for use in patients with infections insensitive to other agents. *DRUG THER*, Vol. 11, #2, p. 35, 1981.

PHYSOSTIGMINE AND DELIRIUM TREMENS:

It has been postulated that the development of delirium tremens is a result of an imbalance which occurs in the adrenergic/cholinergic mechanisms in the central nervous system. Two patients with complicated cases of delirium tremens were treated with intravenous physostigmine and had successful outcomes. Physicians using the drug recommend that further research be designed to determine more extensively the value of physostigmine in the treatment of severe delirium tremens. *J CLIN PHAR*, Vol. 21, #1, p. 57, 1981.

AMYGDALIN:

Amygdalin, also known as vitamin B-17 or laetrile, was tested in six patients with advanced cancer at doses recommended by laetrile users. The patients did not experience side-effects from the oral administration of the drug although the plasma levels of cyanide were noted to be elevated. The long-term use of the amygdalin may produce toxic effects due to the buildup of cyanide in the body. *J AM MED A*, Vol. 245, #8, p. 591, 1981.

TETRACYCLIC ANTIDEPRESSANTS:

A new group of antidepressants used to treat depressive neurosis and manic depression is likely to have several representatives on the market before 1981 is over. Ludiomil, a brand name for maprotiline, is being manufactured by Ciba and is reported to have a more rapid onset of action (yet causes less toxicity) than produced by current tricyclic antidepressants. *FDC RPT*, Vol. 43, #2, p. 1, 1981.

SNAKE BITE:

A regimen for treatment of snakebite has been recommended by a Kentucky physician. He suggests that the bite area be washed well with soap and water, all jewelry and restrictive clothing be removed and tetanus toxoid be used prophylactically. If infection is likely, an antibiotic should be utilized. If the problem is serious, lactated Ringers solution should be given intravenously and blood replacement and heparin therapy used if required. For patients with grade II, III, or IV envenomation, the polyvalent antivenin should be used immediately. *AM FAM PHYS*, Vol. 23, #1, p. 192, 1981.

HEPARIN CALCIUM:

A calcium salt of heparin has been marketed by Choay Laboratories in New York. Calcium heparin is converted to sodium heparin in the body, but the manufacturer claims that the calcium salt produces less pain at the injection site than does the sodium congener. It has been used in low doses to successfully reduce the incidence of deep venous thrombosis. *DRUG THER*, Vol. 11, #2, p. 40, 1981.

NIFEDIPINE:

Nifedipine (Procardia) is a vasoactive agent used to help prevent anginal pain produced by spasm of the coronary vessels. Although the drug has been used for some time, the FDA's cardio-renal drug advisory committee has recommended more testing be done before it is approved for general use. The drug has been used experimentally since 1974. *FDC RPT*, Vol. 42#49, p. 5, 1980.

IATROGENIC ILLNESS:

Iatrogenic illness is defined as any illness resulting from a diagnostic procedure or from any form of therapy. A study of 815 consecutive patients on a general medical service at a university hospital indicated that 36% of the patients suffered a major or minor iatrogenic illness. Nine percent of the 815 admissions had life threatening conditions and in two percent of the 815, iatrogenic illness contributed to the death of the patient. Drugs were responsible for 208 of the 497 recorded complications. Some 19% of the drug induced conditions were considered to be of a major nature. There was a direct relationship between the number of new drugs prescribed and the number and severity of iatrogenic illness. Those without iatrogenic illness received an average of 7.3 new drugs, compared with 11.7 and 17.1 drugs for those with minor and major complications, respectively. The average hospital stay for the three groups was 7.9 days, 13.8 days and 19.3 days. (No mention was made of using the pharmacist to monitor drug therapy! Ed.) *N ENG J MED*, Vol. 304, #11, p. 638, 1981.

ERYTHROMYCIN:

Erythromycin is a weak base macrolide antibiotic which is rapidly decomposed by gastric acid. To help prevent decomposition, the product has been coated with an enteric or time delayed coating, made into an insoluble salt, or prepared as the estolate salt. Literature has suggested that the estolate salt is more completely absorbed, but since it appears in the plasma in both the active and inactive form, it was decided to test it and other erythromycin preparations for in vivo antibacterial activity. The present study suggests that the estolate salt may be more completely absorbed and is found in higher total concentrations than the other forms, but activity produced by the coated preparations and the stearate salt were found to produce activity equal to that produced by the estolate salt after several doses had been

administered. *J CLIN PHAR*, Vol. 20, #1, #12, p. 625, 1980.

MEXILETINE:

Approximately 9% of the patients admitted to a hospital with a diagnosis of a myocardial infarction die within 3 months after they are discharged. Many of these deaths are thought to be due to the development of cardiac arrhythmias, but the value of many antiarrhythmic agents is still felt to be inadequate under these circumstances. Mexiletine, an experimental antiarrhythmic agent, was found to be effective in reducing the risk of ventricular arrhythmias in a high-risk group of patients, but no beneficial effect on overall mortality rate was observed. *LANCET*, Vol. II, #8208, p. 1324, 1980.

IBUPROFEN AND ACETAMINOPHEN:

Twenty-two children with fever were given either ibuprofen (Motrin) or acetaminophen in syrup form and their temperatures were recorded at intervals for up to 12 hours after dosing. The effects produced by both drugs seemed comparable with the exception that the ibuprofen was more effective at the 6 and 8 hour periods. Ibuprofen also has potent anti-inflammatory activity. *J CLIN PHAR*, Vol. 20, #11, #12, p. 672, 1980.

PHENYLPROPANOLAMINE:

Phenylpropanolamine (Propadrine) is an over-the-counter preparation which is similar to amphetamine in structure and pharmacological action. It is available in many different combination products which are used to treat symptoms of the common cold. It is also found in some anorexiant preparations which are available without a prescription. Side effects produced by high doses of phenylpropanolamine resemble those produced by amphetamine and include tremors, restlessness, and hallucinations. *J AM MED A*, Vol. 245, #8, p. 601, 1981.

ASPIRIN AND REYE'S SYNDROME:

Two studies, one conducted in Ohio and the other in Michigan, have concluded that administration of salicylates to children with viral illnesses may be associated with the development of Reye's syndrome. Both studies were prospective in nature and no explanation for the association between salicylates and the syndrome has been found. *DRUG THER*, Vol. 11, #2, p. 41, 1981.

DIABETES MELLITUS:

Patients with diabetes mellitus have been found to have faster resting heart rates than non-diabetic controls. Investigators suggest that their vagus nerve is affected by this disease. Thus the heart rate is increased as vagal function deteriorates. Later the sympathetic component of the autonomic nervous supply to the heart is also affected. *LANCET*, Vol. I, #8213, p. 183, 1981.

INTERFERON:

Since its discovery in 1957, interferon has been investigated constantly. Recent experiments were designed to determine if the endogenous substances have any antineoplastic activity. Results have been mixed, but some clinicians

have noted tumor regression when the interferon is used alone. The variation in response may be due to the differences in purity of the preparations, the delivery method, the dose and/or dosage schedule. Much work is being done in an effort to find out more about this substance. Some feel it produces its antineoplastic activity by causing the cell to make improper DNA molecules which can not be replicated and death of the cell results. *JAM MED A*, Vol. 245, #2, p. 110, 1981.

SEXUALLY TRANSMITTED DISEASES:

Medical progress has reached the point where infections such as smallpox, measles, diphtheria, poliomyelitis and tuberculosis are responsible for only a small number of deaths each year. However, there has been a dramatic increase in the incidence of sexually transmitted diseases and the problems associated with these conditions. Problems are especially serious in young women. The diseases which cause most of the problems include non-specific urethritis, gonorrhea and syphilis. *LANCET*, Vol. I, #8215, p. 315, 1981.

MEZLOCILLIN:

A new semisynthetic penicillin has been used with aminoglycosides to help control infections caused by *Pseudomonas aeruginosa* organisms. The drug is said to have a wider spectrum of activity than similar agents already on the market, and it is said to be less expensive. More research is required to ascertain its overall role in the area of infectious disease. *DRUG THER B*, Vol. 18, #26, p. 102, 1980.

IN-VITRO TESTING:

Toxicological testing is a very expensive procedure utilizing much of our human and animal resources. Plans are being made to study in-vitro methods which may be used ultimately to replace the current model systems. Cell cultures and bioassay procedures may be utilized as acceptable alternatives to the more expensive and time consuming experiments. *FDC RPT*, Vol. 43, #8, p. 10, 1981.

PARKINSON'S DISEASE:

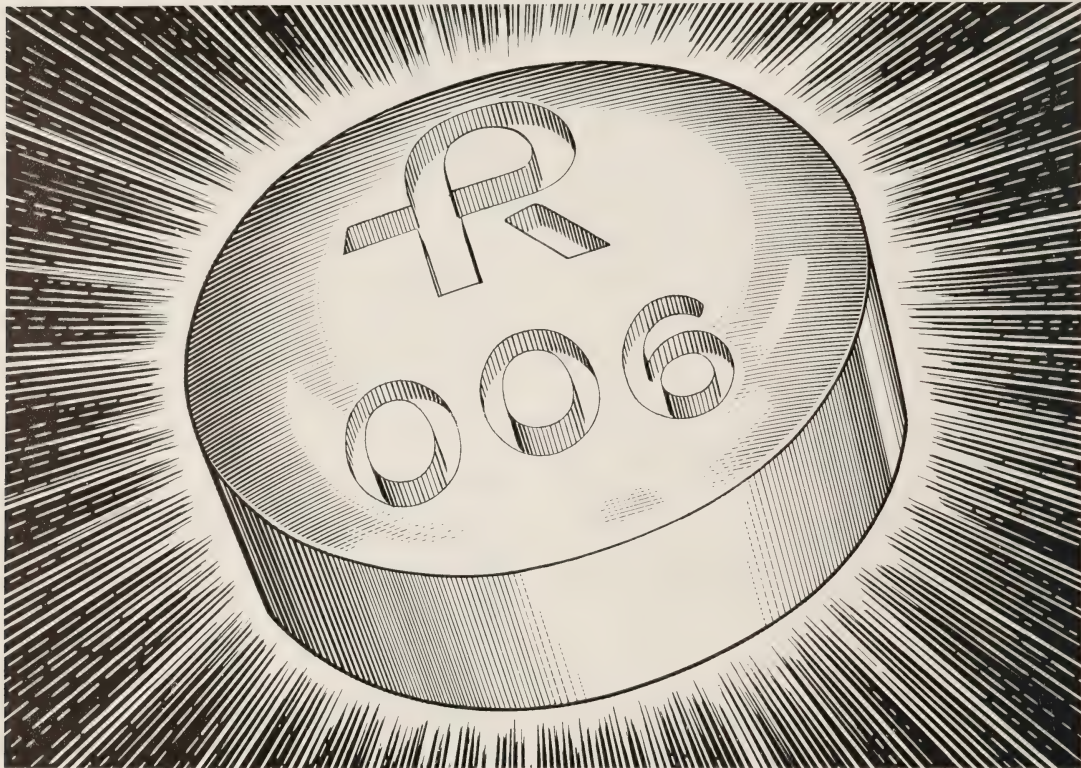
L-DOPA has been used to treat Parkinson's disease for almost two decades. Approximately one-third to one-half of the patients with this condition will receive great benefit from the use of this drug. A retrospective investigation has noted that the drug is likely to prolong survival for about 14 years from the onset of the disease. The authors of this article suggest that therapy be reserved until the condition interferes with work, shopping, etc. When it is used, the dose should be kept as low as is consistent with good functional improvement. *BR MED J*, Vol. 282, #6262, p. 417, 1981.

ALINIDINE:


A new drug has been shown to slow the heart rate without blocking beta-adrenergic receptors in the heart. Alinidine, a drug similar to clonidine (Catapres) in structure, has been found to slow the heart rate without interfering with the activity at the beta receptor. The actual mechanism of action has yet to be determined. *LANCET*, Vol. I, #8216, p. 351, 1981.

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Naplex examination dates The Board of Pharmacy will hold examinations for licensure on the following dates. 1982 — January 26, 27, 28. June 22, 23, 24. 1983 — January 25, 26, 27. June 28, 29, 30. 1984 — January 24, 25, 26. June 26, 27, 28.

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THE MARYLAND PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

October, 1981
VOL. 57
NO. 10



Third Party Programs — The Level of Discontent in Maryland

Oversupply of Pharmacists?

Ralph F. Shangraw, Ph.D.

The Founding of MSHP

Norman Pelissier

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OCTOBER, 1981

VOL. 57

NO. 10

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This issue of the *Maryland Pharmacist* contains an article by Dean Leavitt which analyzes the results of the recent third party survey sent to all pharmacies in the State of Maryland. We consider the response good, with approximately 50% of the questionnaires being returned. Most of these were completed by members of the Association. That medium appears to be an effective means for soliciting guidelines for the Board of Trustees to use to develop future policy and react to current issues. No doubt your Board of Trustees and your Third Party Committee will modify their approach to third parties as a result of the survey. But, the message we received is that the pharmacists of Maryland are generally satisfied with the job being done and we should continue moving in the direction we are now going.

A new survey on other issues facing Maryland Pharmacists will be distributed shortly. One issue, for example, deals with mandatory continuing education. There have been several attempts in the past to establish mandatory continuing education in this State. These efforts have been met with mixed support. Most of the pharmacy organizations in Maryland were in favor of the legislation; however, it was defeated due primarily to the lobbying efforts of one opponent organization. Subsequently, your Board of Trustees chose to put the issue of mandatory continuing education in abeyance until we could get a sense of the desires of the membership. The upcoming survey will hopefully provide the direction that we should seek. Over a year ago we did take one "straw vote" at a general meeting of Maryland Pharmacists. Most of the pharmacists in attendance were opposed to mandatory continuing education in Maryland. I recently attended a meeting of a local pharmacy association in Maryland. They voted, almost unanimously, in favor of mandatory continuing education legislation. If you have strong feelings about this, one way or the other, please inform your Association leadership. In the meantime, when the survey is sent to you, please make sure your input is included in the survey.

Philip Cogan,
PRESIDENT

Third Party Programs

The Level of Discontent Among Maryland Independents

In the Spring of 1981, a questionnaire was mailed to all of the independent pharmacies in the State of Maryland. The project was a joint effort of the Maryland Pharmaceutical Association and the School of Pharmacy. The questionnaire concerned itself mainly with the relationships among the third party providers and the independent pharmacies. An excellent return of over 50% was received from the approximately 420 independents.

The 228 returns were received from the following sections of the state:

Baltimore Metropolitan area	100
Washington Metropolitan area	42
Eastern Shore	19
Western Maryland	17
No geographical designation	50

The respondents reported participation in 39 different third party plans, although six plans appear to be the most important when considered on the basis of participating pharmacies and level of participation: From Table One, the six top plans appear to be — Blue Cross of Maryland with 96.5% participation; Medicaid (93.4%), Associated Prescription Service (88.2%), Pharmaceutical Card System (85.5%), Paid Prescriptions (85.1%) and Prescription Drugs, Inc. (80.7%). Each of the six plans, except Paid Prescriptions provides the majority of the participating pharmacies with 10 or more prescriptions per week.

The levels of discontent with each of the plans are apparent in Tables Two and Three. Table Two deals with recent cancellations of third party plan participation. The plans most often cancelled were Esskay, 1199 National Benefit Fund, Prescription Drugs, Inc., and Prescription Plan Service.

In analyzing the major reasons for cancellation discontent with the third party plans, Table Three, it is apparent that the plans with the highest levels of discontent were:

1. Prescription Drugs, Inc.
2. 1199 National Benefit Fund
3. Iron Workers #16
4. Group Services Plan

Question 2, "Over the past 12 months, has participation in the above plans increased your prescription volume", 52/ of the respondents to the question indicated yes while 29.4/ indicated no and 18.6/ were unsure.

Question 3 asked for the need of continuing education in the third party area. The majority (67.8%) felt there was a need for such CE not only for the pharmacists but as often for the third party plan administrator as well. Practitioners were interested in such things as:

- a. Plan guidelines and limitations
- b. Dealing with third party plans
- c. Rules/regulations/fees/policies
- d. Simplified billing and collection systems
- e. Plan updates and solving common problems

TABLE ONE

RESPONDENTS' PARTICIPATION IN THIRD PARTY PLAN, n=228

THIRD PARTY PLAN	Currently Participating Percent of returned	Level of Participation Percent of those reporting participation*	
		Less than 10 Rx's/week	10 or more Rx's/week
1. Aetna Life & Casualty	45.2	77.9	21.2
2. Assoc. Presc. Service (APS)	88.2	33.3	61.2
3. Blue Cross of Maryland	96.5	5.0	83.6
4. Esskay	25.4	94.8	5.2
5. Group Services Plan	51.3	66.7	29.1
6. Iron Workers #16	37.3	89.4	5.9
7. Medicaid	93.4	9.4	85.0
8. Metropolitan	35.5	81.5	16.1
9. 1199 National Benefit Fund	15.4	82.9	17.1
10. Paid Prescriptions	85.1	55.7	39.2
11. Pharmaceut. Card System (PCS)	85.5	36.9	58.0
12. Pharm. Services Fdn.	24.1	78.2	16.4
13. Prescription Drugs, Inc. (PDI)	80.7	29.4	66.3
14. Prescription Plan Service	11.0	88.0	12.0
15. Travelers' Insurance	52.6	78.3	15.8

* Does not always total 100% because of incomplete questionnaires

TABLE TWO
THIRD PARTY CANCELLATIONS

THIRD PARTY PLAN	Percent of Current Participants	
	In past 6 months	In past 12 months
1. Aetna Life & Casualty	0.96	2.9
2. Assoc. Prescription Service (APS)	0.50	
3. Blue Cross of Maryland		
4. Esskay	5.2	5.2
5. Group Services plan	0.9	1.7
6. Iron Workers #16		5.9
7. Medicaid	0.5	
8. Metropolitan	1.2	3.7
9. 1199 National Benefit Fund		17.1
10. Paid Prescriptions	0.5	2.1
11. Pharmaceutical Card System (PCS)	2.1	0.5
12. Pharmaceutical Services Fdn.	1.8	1.8
13. Prescription Drugs, Inc. (PDI)	9.8	2.2
14. Prescription Plan Service	4.0	12.0
15. Travelers' Insurance		0.8

Question four requested information on the current usage of computers in community practice. Only 7.3% of the respondents reported the use of a computer system. Nine respondents used in-house systems, 6 were on line, and one specified a hybrid system combining the 3 PM and Healthcare systems.

Question five dealt with geographical area of practice and was used to subdivide the returned data. A superficial analysis indicates no special problems for any area, just a number of different third parties with which to deal.

The majority of the respondents were MPhA members (73.3%) and twice as many respondents felt that the Association had done a good job in the third party area, 49.8% vs. 20.5%.

Suggested areas of MPhA activity were:

1. Pharmacist voice in plans
2. Seek exemption from antitrust for collective negotiation

3. Usual and customary fees
4. Challenge the antitrust laws
5. Publish individual pharmacist's views and actions
6. Increase fees
7. Stop discounting of co-pay
8. Universal form
9. Percentage markup system rather than a professional fee
10. Interest on slow paying plans
11. Form a corporation to process claims

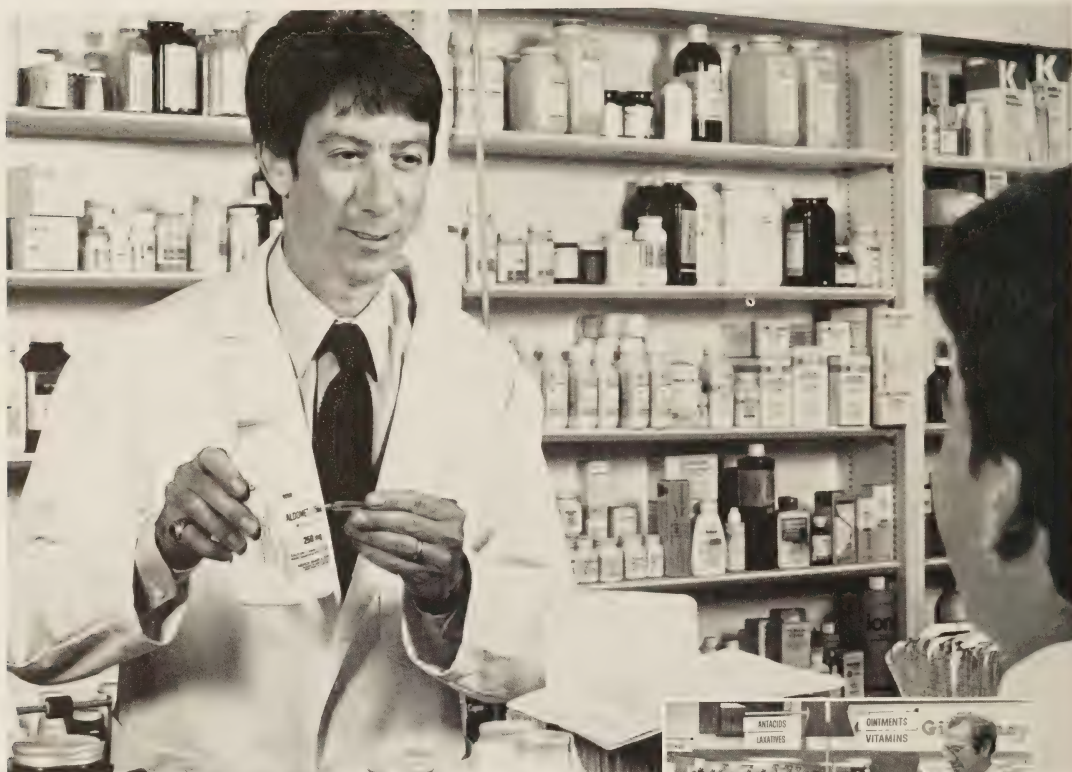
The frustration of the limits of group action is apparent throughout the responds. It was felt that this frustration and impotency of individual action against third party acts reduced the return and the expressions of discontent with the plans. If there were a more effective way of dealing with the plans and thereby some of hope of remediation, a much louder protest would be generated until some of the major problems were solved.

Special Thanks to Dean Leavitt, Ph.D.
for compiling the results of this survey.

TABLE THREE
MAJOR REASONS FOR CANCELLATION/DISCONTENT

THIRD PARTY PLAN	Dispensing Fee	Days Supply	Percent of Participants		General Attitude
			Slow Pay	Cost Cutbacks	
1. Aetna Life & Casualty	13.5	7.7	13.5	6.7	5.8
2. Assoc. Prescription Service (APS)	32.8	10.6	28.9	5.0	4.5
3. Blue Cross of Maryland	10.9	5.9	1.8	1.4	0.9
4. Esskay	31.0	3.5	3.5		
5. Group Services Plan	41.9	4.3	27.4	6.8	12.0
6. Iron Workers #16	45.9	2.4	18.8	1.2	7.1
7. Medicaid	20.2	7.0	12.2	9.9	8.0
8. Metropolitan	23.5	3.7	21.0	3.7	7.4
9. 1199 National Benefit Fund	45.7		25.7	5.7	20.0
10. Paid Prescriptions	28.9	8.8	15.0	7.2	11.3
11. Pharmaceutical Card System (PCS)	23.1	6.7	17.4	4.6	10.8
12. Pharmaceutical Services Fdn.	21.8	1.8	23.6	1.8	3.6
13. Prescription Drugs, Inc. (PDI)	47.8	6.5	23.4	18.5	23.9
14. Prescription Plan Service	28.0		8.0	8.0	4.0
15. Travelers' Insurance	18.3	4.2	6.7	0.8	2.5

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Oversupply of Pharmacists In Maryland?

by

Ralph F. Shangraw

Professor and Chairman
Department of Pharmaceutics
University of Maryland
School of Pharmacy

CHARGE: THE UNIVERSITY OF MARYLAND IS GRADUATING TOO MANY PHARMACY STUDENTS

PLEA: NOT GUILTY

For the past few years it has been difficult to have any lengthy discussions with groups of practicing pharmacists without the question of manpower being raised. In most cases, the practitioners voice their concern over the increasing number of pharmacy students and the decreasing number of positions available to pharmacists. Certainly the figures of pharmacy school enrollments nationwide (up from 12,362 in 1965 to 22,500 in 1979 with a peak of 23,830 in 1975) or the help wanted ads in the Sunday newspaper (more positions for physical therapists than for pharmacists) might provide some cause for alarm. However, a State university has an obligation to supply the manpower needed to provide a high level of professional care to the citizens of that State. And while members of any profession may feel more secure with a shortage of supply, the public, and to a degree the profession, is penalized by such a shortage.

The number of pharmacists registered in Maryland compared to the number of graduates from the University of Maryland School of Pharmacy, since the inception of the 5 year program in 1964 are shown in Table I and illustrated in the bar graph figure.

During the 17 year period, the number of graduates from the University of Maryland School of Pharmacy have made up on the average only 30 percent of the total number of pharmacists that have been registered in the State. Both the number of registrants and the number of graduates have increased, but the number of graduates has appeared to peak and is now decreasing. After a peak of 100 graduates in 1979, only 93 students graduated in 1980 and 90 in 1981. On the other hand, the number of pharmacists registered in the study appears to continue to go up.

It seems quite clear from this data, that the University of Maryland School of Pharmacy is not graduating too many

pharmacists to meet the needs of the State. As a matter of fact, a case could be made that the School is not graduating enough pharmacy students. Like all states with one or two large population centers, there is a maldistribution of pharmacists, and positions are available today in a number of non-urban areas. The utilization of pharmacists in hospitals is more highly developed in Maryland, than in many other states. Maryland has traditionally been a "user" rather than a provider of pharmacists. Other states on the Atlantic Coast, notably Pennsylvania and Massachusetts, graduate many more pharmacists than their states need, and many of these pharmacists became registered in Maryland by examination or reciprocity.

PHARMACISTS REGISTERED IN MARYLAND AND GRADUATES OF THE UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY SINCE THE INCEPTION OF THE FIVE YEAR B.S. PROGRAM

	PHARMACISTS REGISTERED IN MD.			MD. SCHOOL OF PHARMACY GRADUATES	
	Exam	Reciprocity	Total	Number	Percent of Total Pharmacists Registered
1964-65	11	63	74	2	3
65-66	64	44	108	25	23
66-67	58	61	119	30	25
67-68	41	61	102	28	27
68-69	60	84	144	35	24
69-70	93	75	168	40	24
70-71	112	92	204	48	24
71-72	133	67	200	47	24
72-73	96	94	190	39	21
73-74	111	88	199	61	31
74-75	113	76	189	62	33
75-76	109	89	198	62	31
76-77	166	78	244	76	31
77-78	150	91	241	80*	33
78-79	137	113	250	97*	39
79-80	180	73	253	100*	40
80-81	183	88	271	93*	34
TOTAL	1817	1337	3154	925	29

* Includes Pharm D. Graduates

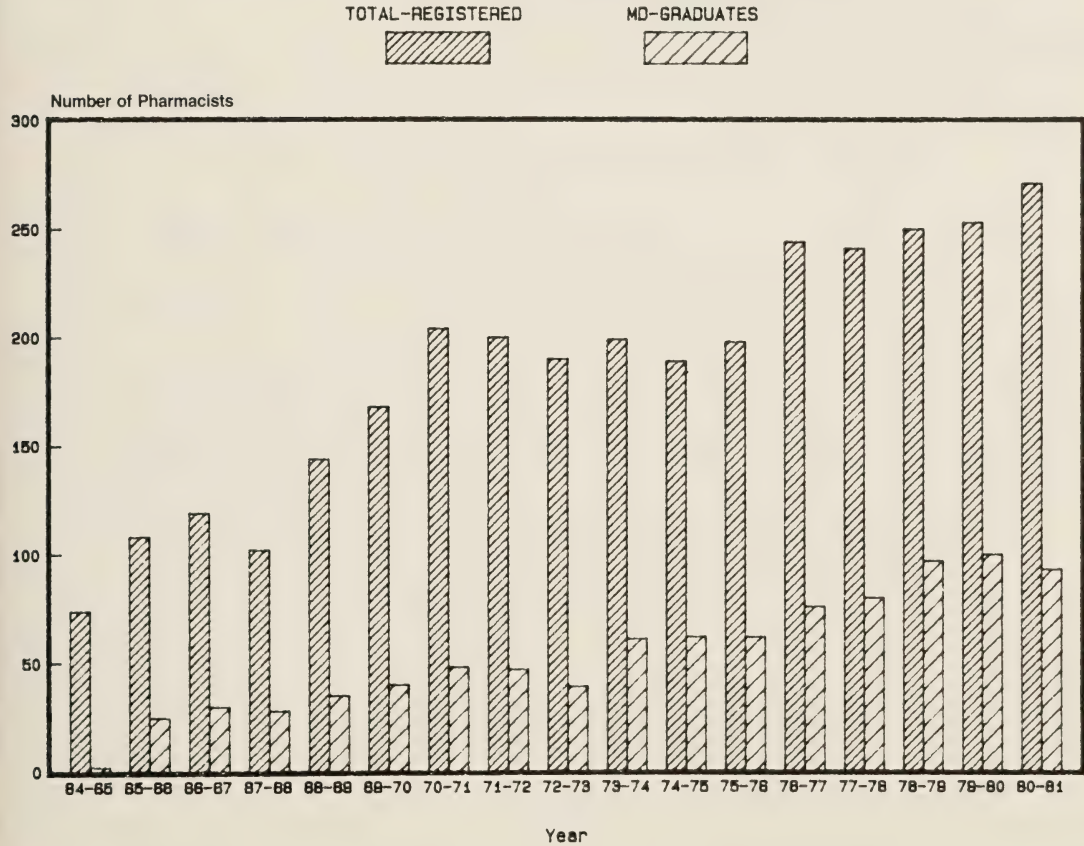
It is fair to say that the University of Maryland has demanded excellence of its students through the years. The strength of any profession within the State will always rest to a large extent on the shoulders and the quality of its own university graduates. Pharmacists who have grown up in Maryland, attended the University of Maryland and plan to practice in Maryland the rest of their lives are more likely to become leaders in Association work, members of the Board of Pharmacy or clinical faculty for the School. It would not be in the best interests of the State for its own university to supply any smaller fraction of the State's pharmacists than presently exists in Maryland.

Education in general and pharmacy education, in particular, faces a crisis in the next decade as the competition for the best students becomes more and more intense. It is important that pharmacists in the State continue to support recruiting efforts by the School in order that the quality of the students and the excellence of the School which depends upon that quality, be maintained.



VERDICT: INNOCENT OF THE CHARGE

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The Founding of MSHP

by
Norman Pelissier



(continued from September)

GUIDELINES PROJECT

Although the Society has obviously been involved with numerous projects, legislation, programs, etc. over the years, the "Guidelines" project is described here because this project involved the efforts of many members over a span of more than thirteen years — nearly a third of the time the Society has existed. During this time two key figures were involved with this project more than any other members: Henry Derewicz and Robert Snyder.

Under the title "Suggested Principles and Guidelines for Pharmacy Services in Hospitals", the "Guidelines" originated in 1968. President Peter Lamy discussed this project with Charles E. Burbridge, incoming president of the Tri-State Hospital Association. Henry Derewicz was appointed by Lamy to the Pharmacy Advisory Committee of this association. In November of that year, the Tri-State Hospital Association approved the appointments of Derewicz, Sister Mary Constantia of Georgetown Hospital and Stanley Weinberg of Wilmington who were to work as a committee on drafting the Guidelines. The purpose of the Guidelines was to:

- (1) protect the safety and welfare of patients who receive drugs while in the hospital,
- (2) guide individual hospitals in establishing their own specific policies and procedures for the safe use and distribution of pharmaceuticals within their own institution, and
- (3) recognize the interdependence of the medical care team members in the hospital who participate in the acts associated with drug treatment or usage.

The first draft of the Guidelines was approved by the MSHP Board of Directors in June 1969. The following organizations also reviewed and approved this first draft which was patterned after a similar set of guidelines developed by the State of Michigan.

MARYLAND

Medical and Chirurgical Faculty of the State of Maryland
Maryland Nurses Association
Hospital Council of Maryland
Maryland Society of Hospital Pharmacists
Maryland Pharmaceutical Association
Maryland State Board of Pharmacy

DISTRICT OF COLUMBIA

D.C. Medical Society
D.C. Nurses Association
Hospital Council of the National Capital Area
D.C. Society of Hospital Pharmacists
D.C. Board of Pharmacy

DELAWARE

Delaware Medical Society
Delaware Nurses Association
Association of Delaware Hospitals
Delaware Pharmaceutical Society

By October 1969, a copy of the Guidelines had been sent to all hospital administrators in Maryland by the Maryland Hospital Association. Distribution was planned for the Tri-State area by the Maryland-D.C.-Delaware Hospital Association and this item appeared on their annual program agenda for the December 1969 meeting held at the Washington Hilton.

In February 1970 President Lichter received correspondence from the Tri-State Hospital Association concerning substantial costs incurred in printing and distributing the Guidelines. It was decided that further copies would be printed by the Society. In September, Derewicz and Lichter, working through the Pharmacy Liaison Committee of the Maryland Hospital Association, sought to have the Guidelines implemented. A committee consisting of Snyder, Lichter, and Pelissier was organized to decide on the final design and format and the MSHP Legislative Committee was charged with seeking their implementation.

In March 1971 President Snyder had the first typeset copies of the Guidelines sent to each hospital administrator and MSHP member. The MPhA Executive Committee voted to help defray part of the printing expenses. A cover letter was sent to each Director of Pharmacy and each

Director of Nursing in Maryland. The following month Derewicz discussed implementation of the Guidelines with the Professional Practices Committee of the Maryland Hospital Association. This group approved the Guidelines as Snyder announced at the June 1971 MSHP meeting. The next step was to seek assistance of this committee in going before the Maryland Board of Pharmacy.

In August 1971 the MSHP Board of Directors and Derewicz met with Francis S. Ballassone and other State Board of Pharmacy members to discuss how the Guidelines could be introduced as legislation. The Board suggested that the Guidelines first be rewritten into legislative language. In October 1971 the MSHP met with Attorney Joseph Kaufman. Also present were Paul Freiman and Nathan Gruz of the Maryland Pharmaceutical Association and Henry Derewicz. Mr. Kaufman also suggested the Guidelines should be first rewritten into legal terminology.

The following month a Guidelines Committee, co-chaired by Snyder and Derewicz, met with Kaufman to discuss the rewriting. Shortly afterwards, upon learning of the American Society of Hospital Pharmacists (ASHP)'s interest in the Guidelines, Snyder and Derewicz began a series of eight meetings with ASHP attorney Carl DeMarco and his associate Jack White in Washington. Many full day sessions ensued as the task of putting the Guidelines into legal terminology continued. Meanwhile, the Board of Pharmacy approved the Guidelines in principle. In September 1972, Board Chairman Mary Connelly announced that the Maryland Hospital Association had ratified the Guidelines but Snyder and Derewicz were still meeting with Carl DeMarco at ASHP headquarters for the rewriting into legal language.

At the Annual MSHP Seminar in Ocean City in 1973, DeMarco presented a speech entitled "A Model Institutional Pharmacy Law in Maryland". DeMarco was interested in presenting the Uniform Institutional Pharmacy Law to ASHP's council on Legal and Public Affairs for their recommendation to the ASHP House of Delegates for adoption as a national Model Institutional Pharmacy Law.

A revision was presented to the MSHP Board of Directors by Snyder in September 1973. It was decided to appoint a committee to recommend a plan of action in presenting this work to other State organizations such as the MPhA, MHA, School of Pharmacy, Board of Pharmacy, Tripartite Committee, etc. Board Chairman Pelissier appointed an ad hoc committee called the Committee on Pharmaceutical Practice with Derewicz as chairman. Other members included Snyder, Lamy, Jaffe (from Eastern Shore), Patrick, Burkhardt, Fortner, Birmingham, and Telak. The purpose of this committee was to review and modify if necessary the "Uniform Institutional Pharmacy Law" as revised with ASHP and to seek implementation in Maryland. This committee met about six times through March 1974. The committee favored the regulatory route rather than seeking a change in Pharmacy Law.

The resulting work was sent to MSHP members by President Patrick in April 1974 and members were asked for their comments. Derewicz and the MSHP Legislative Committee were to meet with the MPhA and the State Board of Pharmacy to obtain their comments and suggestions for implementation. The Guidelines were revised several times over the next three years as efforts were made to meet suggestions and requirements of all affected health groups. In July 1977, about ten years after this project actually began, Derewicz proposed to the Board that the present Guidelines appeared to be the best compromise for acceptance by all concerned parties.

A February 1978 redrafting of the Guidelines, now called "Proposed Institutional Pharmacy Regulations", deleted references to mandatory continuing education. At this point the Guidelines were forwarded by the Board of Pharmacy to Assistant Attorney General Standish McCleary III who then revised them to conform to the Maryland Board of Pharmacy's jurisdiction. They were returned to the Board in February 1979.

In March 1979, MSHP Board Chairman Art Riley called a special meeting at the Maryland General Hospital to con-



MSHP officers and members from previous years are shown (left to right) Norman Pelissier, Dudley Demarest, Robert Snyder, June Shaw, Thomas Patrick, and Samuel Lichter.



David Rothman (right), now a member of the Clinical Faculty of the School of Pharmacy, is shown in 1970 receiving the Student Achievement Award from Robert Snyder.

sider recent developments in the implementation of the institutional pharmacy regulations. Present were Snyder, Derewicz, Birmingham, Burkart, Connelly, Fortner, Lamy, Lichter, Patrick, Pelissier, Shaw, and members of the MSHP Board of Directors. The changes were approved by the Board. The document then went to Harold Gordon, chief of the division of licensing and certification. Mr. Gordon listed several objections which were forwarded to deputy secretary Leonard Albert of the department of Health and Mental Hygiene. A meeting was held in June 1979 to discuss Mr. Gordon's concerns. Mr. Albert then instructed the Board of Pharmacy and the Division of Licensing and Certification to meet and resolve the question as to who should be licensing and inspecting institutional pharmacies. A meeting was scheduled for October 1979.

Finally, hearings were scheduled beginning in May 1980. It was hoped at that time that the regulations would be passed by the summer of 1980. A special meeting of the Board of Pharmacy in November 1980 resulted in further changes such that the regulations had to be resubmitted to the Hearing Coordinator for another hearing. All references to nursing homes in the regulations were deleted. Another hearing was scheduled for May 1981. The Board of Pharmacy was advised that the word "Agent" in the previous draft was in violation of Maryland Law. This word was replaced by "qualified supervised assistant". Another hearing would have to be scheduled.

At the time that this article was going to press, the latest revision of the proposed regulations was being circulated for the required signatures and another hearing was in process of being scheduled. Final approval of the regulations is expected soon but then again . . .

The W. Arthur Purdum Award

The Society's most prestigious award, the W. Arthur Purdum Award, is named in honor of Maryland's pioneer in the development of hospital pharmacy practice, and an early leader and past-president of the American Society of Hospital Pharmacists. This award is presented to the person who has made the most significant or sustained contribution to hospital pharmacy in Maryland.

Dr. W. Arthur Purdum was a Baltimorean who attended the University of Maryland School of Pharmacy earning his B.S. degree in 1932, his M.S. degree in 1934 and his Ph.D. in 1941. He was on the Staff of the School of Pharmacy as a laboratory assistant in 1930 and remained on the School Staff except for two years in 1939-1941 while he was Assistant Professor of Pharmacy at the University of Georgia. He was appointed Professor of Hospital Pharmacy at the University of Maryland School of Pharmacy in 1947 which position he held at the time of his death in 1965. In 1950, Dr. Purdum became the first recipient of ASHP's highest honor, the Harvey A. K. Whitney Lecture Award.

In addition to his teaching duties, Dr. Purdum was Chief Pharmacist at the Johns Hopkins Hospital 1945-1960, and Vice President for Production and New Product Development at Burrough Brothers Manufacturing Co. 1960-1965.

The institution of the Purdum Award was recommended to the MSHP Board of Directors in February, 1970. At first,

the Seminar Committee was responsible for choosing nominees and presenting their names to the Board of Directors for its final choice. Later, a selection committee was formed consisting of former award recipients. Dr. Peter P. Lamy was responsible for suggesting and obtaining approval for the use of the name of W. Arthur Purdum for this award. The Purdum Award is not necessarily given every year nor is the recipient necessarily a pharmacist.

The Pfizer Hospital Pharmacist of the Year Award

In 1972, Pfizer Laboratories announced its intention to implement a program that would honor one hospital pharmacist in each state society on an annual basis. The objective of the program was to honor the hospital pharmacist who had performed outstanding services to hospital pharmacy, to the profession, and to his community. The first recipient of this award was selected by the Board of Directors in 1975. Later a selection committee was formed.

The criteria upon which the committee chooses a recipient is professional excellence in hospital pharmacy, as demonstrated by the nominee's role in providing outstanding pharmacy service, contributions to the professional literature, research, or teaching activities. Unlike the Purdum Award, the Hospital Pharmacist of the Year Award must be awarded to a hospital pharmacist and it is given every year.

The Student Achievement Award

Recipients of the Outstanding Senior Student Achievement Award are selected by the faculty of the School of Pharmacy. Among the criteria is outstanding work in the institutional pharmacy course of the School of Pharmacy.

Other Awards

The Geigy Achievement Award and the Squibb Past President's Award are given annually to the outgoing president of the Society.

PAST AWARD RECIPIENTS

W. Arthur Purdum Award

1970	Sydney L. Burgee, Jr.
1971	Paul J. LeSage
1972	Mary W. Connelly
1973	Peter P. Lamy, Ph.D.
1974	Henry J. Derewicz
1975	George H. Yeager, M.D.
1976	Francis S. Ballassone (posthumous)
1977	Robert E. Snyder
1978	no award given
1979	Clarence L. Fortner
1980	no award given
1981	Gordon A. Mouat (posthumous), and William R. Grove

Pfizer Hospital Pharmacist of the Year Award

1975	June H. Shaw
1976	Gerald W. John
1977	William R. Grove
1978	Steve S. Cohen
1979	John Bender
1980	Bonnie Pitt
1981	Bonnie Levin

Student Achievement Award

1967	Frank Frankenfeld
1968	Karen Rosenbluth Blender
1969	Kathleen Lunz Trunk
1970	David S. Roffman
1971	Marsha E. Fruchtbaum
1972	Raymond W. Morris
1973	Linda W. Bosco
1974	Pamela K. Lindsay
1975	Daniel R. Weber
1976	Sherry L. Williams
1977	John W. Young
1978	Mark F. Kern
1979	Mary Jane Eckert
1980	Aliceann Scharf
1981	Gary Magnus

Prior to 1981, the recipient of the Student Achievement Award attended the Society's Annual Seminar during which time the recipient was recognized as having received the award. The official award is presented at the Convocation exercise of the University of Maryland School of Pharmacy.



Peter P. Lamy, Chairman of the Department of Pharmacy and Administrative Sciences at the School of Pharmacy, served as President of the MSHP in 1968.

Members of the Maryland Association of Hospital Pharmacists, 1944-1953

Name	Hospital
Angela R. Allen	South Baltimore General
Reuben Alperstein (D)	Sinai
Elizabeth C. Cassidy	Johns Hopkins
Jerome J. Cermak	Johns Hopkins
Sister Mary Carmel Clarke (D)	Mercy
Mary Ann Coleman	Women's
Franklin D. Cooper	George Washington University
Dudley A. Demarest	North Arundel
Harriet Finney	Washington County
Charles Friedman (D)	Johns Hopkins
Robert Fuqua (D)	Johns Hopkins
Elmer A. Gissel (D)	Fort Howard V.A.
Harry Goldberg (D)	Sinai
Shirley Greenberg	Church Home
Frank Gregorek (D)	Johns Hopkins
William Melvin Hanna	U.S. Marine
Sister M. St. Henry	St. Joseph Hospital
Clara Herskowitz (D)	Baltimore City
George Hutchinson	Perry Point Public Health
William Hutchinson	Franklin Square
Milton Klepfish	West Baltimore General
Leo Lathroum	University of Maryland
Blanche Leites	Women's
Anthony Mentis	Union Memorial
J. Vernon Michael	South Baltimore General
Irving Morris	Union Memorial
Marius Moscati (D)	Baltimore City
Gordon A. Mouat (D)	Maryland General
Harriett Noel	University of Maryland
Alexander O'Grinz	Johns Hopkins
W. Arthur Purdum (D)	Johns Hopkins
Stephen W. Ruth	Church Home
John A. Scigliano	National Institutes of Health
Milton W. Skolaut	Johns Hopkins
Kenneth G. Spangler	Johns Hopkins
Sister Mary Rita Spellman (D)	Mercy
John W. Shea	Memorial (Cumberland)
Frank Steele	Johns Hopkins



Sydney L. Burgee, Jr. (left) and Samuel Lichter (right) both served as Presidents of the Society and are shown during an awards ceremony.

Maryland Society of Hospital Pharmacists

YEAR	PRESIDENT	VICE PRESIDENT	SECRETARY-TREASURER	
1944	Gordon A. Mouat (D) Maryland General	Anthony Mentis Union Memorial	Harriett Noel University of Md.	
1945	Anthony Mentis Union Memorial repl. 1/46 by Milton W. Skolaut Johns Hopkins	Milton W. Skolaut ¹ University of Md.	Frank Steele Johns Hopkins repl. 6/45 by Blanche Leites Women's Hospital ²	
1946	Blanche Leites Women's Hospital	Dr. W. A. Purdum ³ (D) Johns Hopkins	Angela Allen So. Balto. General	
1947	Dr. W. A. Purdum (D) Johns Hopkins	Blanche Leites Women's Hospital	Angela Allen So. Balto. General	
1948	Milton Klepfish WBGH ⁴	John W. Shea Memorial Hosp. Cumberland	REC. SEC. TREAS. Wm. Melvin Hanna U.S. Marine Hosp. ⁵	CORR. SEC. Marius Moscati (D) Balto. City.
1949	Marius Moscati (D) Balto. City	Kenneth G. Spangler Johns Hopkins	Mary Ann Coleman Women's Hospital	Milton Skolaut Johns Hopkins
1950	Kenneth G. Spangler Johns Hopkins	Sr. Mary Rita Spellman (D) Mercy Hospital	Mary Ann Coleman Women's Hospital	Charles Friedman (D) Johns Hopkins
1951	Dr. John A. Scigliano NIH-Bethesda	Charles Friedman (D) Johns Hopkins	Stephen W. Ruth Church Home	Frank Gregorek (D) Johns Hopkins
1952	Dr. John A. Scigliano NIH-Bethesda	Charles Friedman (D) Johns Hopkins	Mary Ann Coleman Women's Hospital	Dudley A. Demarest North Arundel
1953	Stephen W. Ruth Church Home	Eliz. C. Cassidy ⁶ Johns Hopkins	Mary Ann Coleman Women's Hospital	Dudley A. Demarest North Arundel
1954	Stephen W. Ruth Church Home	Eliz. C. Cassidy Johns Hopkins	Mary Ann Coleman Women's Hospital	Dudley A. Demarest North Arundel
1955	Dr. John A. Scigliano NIH-Bethesda	Eliz. C. Cassidy Johns Hopkins	Mary Ann Coleman Women's Hospital	Dudley A. Demarest North Arundel
1956	Wm. H. Briner NIH-Bethesda	Mary R. DiGristine Mercy Hospital	SECRETARY Mary W. Connelly Eastpoint Medical Health Center	TREASURER Dudley A. Demarest North Arundel
1957	Wm. H. Briner NIH-Bethesda	Mary R. DiGristine Mercy Hospital	Mary W. Connelly Eastpoint Medical Health Center	Dudley A. Demarest North Arundel
1958	Walter F. Flayhart USPHS-Baltimore	Karl Holtgreve USPHS-Baltimore	Mary W. Connelly Eastpoint Medical Health Center	Judith Laegler ⁷ Johns Hopkins
1959	Robert E. Lawson University of Md.	Dr. John Scigliano NIH-Bethesda	Mary W. Connelly Eastpoint Medical Health Center	Judith Laegler Johns Hopkins
1960	Robert A. Statler ⁸ V.A. Central Wash.	Robert E. Lawson University of Md.	SECRETARY-TREASURER Mary W. Connelly Eastpoint Medical Health Center	
1961	E. W. Nollau Women's Hospital	Ursula E. Heyer Johns Hopkins	Mary W. Connelly Eastpoint Medical Health Center	
1962	Paul Magalian V.A. Central Wash.	Larry H. Pozanek Lutheran Hospital	Mary W. Connelly Eastpoint Medical Health Center	
1963	Larry H. Pozanek Lutheran Hospital	Wesley R. Gladhart USPHS-Baltimore	Mary W. Connelly Eastpoint Medical Health Center	
1964	Luis Hernandez Johns Hopkins	Theodore J. Benya University of Md.	Mary W. Connelly Eastpoint Medical Health Center	
1965	James B. Low V.A.-Baltimore	Sydney L. Burgee Union Memorial	Mary W. Connelly	
1966 ⁹	Sydney L. Burgee Union Memorial	Paul J. LeSage USPHS-Baltimore	Mary W. Connelly	
1967	Paul J. LeSage USPHS-Baltimore	Dr. Peter P. Lamy University of Md.	SECRETARY Mary W. Connelly	TREASURER Charles Gordon Keswick
1968	Dr. Peter P. Lamy University of Md.	(Position replaced by President Elect)	Rheta E. Skolaut University of Md.	Patrick H. Birmingham Good Samaritan
1969	Samuel Lichter ¹⁰ Union Memorial		Sr. Eileen Healy St. Agnes repl. 9/69 by Rheta Skolaut repl. 11/69 by Normand A. Pelissier	Dudley A. Demarest North Arundel
1970	Robert E. Snyder ¹¹ Maryland General		Normand A. Pelissier Union Memorial	Thomas E. Patrick University of Md.

YEAR	PRESIDENT	SECRETARY	TREASURER
1971	Mary W. Connelly Mercy Hospital	Dolores A. Ichniowski Greater Balto. Medical Center	Thomas E. Patrick University of Md.
1972	Normand A. Pelissier Union Memorial	Vincent de Paul Burkhardt University of Md.	Harry Hamet Johns Hopkins
1973	Thomas E. Patrick University of Md.	Thomas Walker USPHS-Baltimore	Harry Hamet Johns Hopkins
1974	Vincent de Paul Burkhardt University of Md.	Kent T. Johnson USPHS-Baltimore	Ronald C. Telak Maryland General
1975	Harry Hamet Johns Hopkins	Michael Luzuriaga Maryland General repl. 9/75 by David R. Chason Mercy Hospital	Ronald C. Telak Maryland General
1976	Clarence L. Fortner Balto. Cancer Research Center	David R. Chason Mercy Hospital	Ronald C. Telak Maryland General
1977	Arthur N. Riley University of Md.	David M. Arrington Johns Hopkins	Ronald C. Telak Maryland General
1978	David R. Chason Mercy Hospital	Karen B. Demsky University of Md.	David M. Arrington Johns Hopkins
1979	Ronald C. Telak Maryland General	Karen B. Demsky University of Md.	David M. Arrington Johns Hopkins
1980	Patrick H. Birmingham St. Joseph Hospital	Patricia A. Ensor Union Memorial	Joseph M. Ruppel Mercy Hospital
1981	William R. Grove Baltimore Cancer Research Facility	Patricia A. Ensor Union Memorial	Joseph M. Ruppel Mercy Hospital

1. Milton Skolaut was president of ASHP 1963-1964.
2. Women's Hospital, formerly located at Lafayette and John Streets, became the Greater Baltimore Medical Center in 1964.
3. Dr. Purdum was president of ASHP 1948-1949.
4. West Baltimore General Hospital became Lutheran Hospital around 1950.
5. The U.S. Marine Hospital later became the USPHS Hospital, Wyman Park.
6. Now Mrs. Milton Sappe.
7. Later became Judith Kistler.
8. Mr. Statler was vice president of ASHP 1963-1964.
9. Name changed from Maryland Association of Hospital Pharmacists to the Maryland Society of Hospital Pharmacists in 1966.
10. Mr. Lichter served also as president of the Maryland Pharmaceutical Association in 1980.
11. Mr. Snyder was appointed to the Maryland Board of Pharmacy in 1975.

(D) Deceased

Annual Seminars Maryland Society of Hospital Pharmacists

YEAR	DATES	HOTEL	LOCATION
1966	6/24-6/26	Diplomat Motor Hotel	Ocean City
1967	6/9-6/11	Diplomat Motor Hotel	Ocean City
1968	6/14-6/16	Carousel Motel	Ocean City
1969	6/6-6/8	Carousel Motel	Ocean City
1970	6/12-6/14	Carousel Motel	Ocean City
1971	6/11-6/13	Carousel Motel	Ocean City
1972	6/9-6/11	Carousel Motel	Ocean City
1973	6/15-6/17	Diplomat Motor Hotel	Ocean City
1974	6/28-6/30	Cascades and Motor House	Williamsburg, VA
1975	6/6-6/8	Sheraton-Fontainebleu Inn	Ocean City
1976	6/18-6/20	Sheraton-Fontainebleu Inn	Ocean City
1977	6/17-6/19	Sheraton-Fontainebleu Inn	Ocean City
1978	6/16-6/18	Cascades and Motor House	Williamsburg, VA
1979	6/22-6/24	Hotel Hershey and Country Club	Hershey, PA
1980	6/20-6/22	Sheraton-Fontainebleu Inn	Ocean City
1981	6/19-6/21	Carousel Hotel	Ocean City

ASHP Offers "Clinical Pharmacy"

The American Society of Hospital Pharmacists (ASHP) has unveiled plans to introduce a new major bimonthly journal focusing on drug therapeutics to begin publication in January 1982.

Clinical Pharmacy, concentrating on the safe and rational use of drugs in humans, especially as they relate to the patient care responsibilities of pharmacists, will debut at the 16th Annual Midyear Clinical Meeting in New Orleans. The new journal reflects "ASHP's commitment to serving the expanding clinical information needs of pharmacists," according to ASHP Executive Vice President Joseph A. Oddis, Sc.D.

Subscription rates for the new *Clinical Pharmacy* journal are \$25 for ASHP members, \$15 for student members and \$35 for nonmembers and institutions. (Another rate schedule applies to non-U.S. subscribers.)

For more information, contact: ASHP, 4630 Montgomery Ave., Washington, D.C. 20814.

NARD Employees Manual

The National Association of Retail Druggists has published the "NARD Employee Training Manual", designed to instruct both new and veteran employees about the unique features which make up an independent drug store and to offer suggestions on how they might best serve their employees, their customers, and themselves.

Presented in an easy-to-read, well illustrated format, the manual stresses the importance of each employee doing the best work possible. "Each of us in our independent store realizes that when the store benefits, we benefit," the manual says. "The number of hours available for us to work and the salary money available for pay raises depend directly on the store's sales and profits."

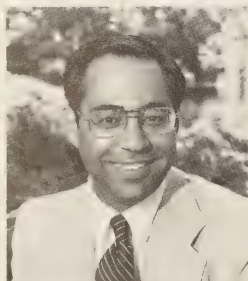
One copy of the manual will be made available free, upon request, to NARD members. Additional copies may be purchased at the following rates: Non-members, \$5.00 each; Members, \$3.00 each; 25 or more, Non-members, \$4.00 each; Members, \$2.00 each.

Our best friends are our severest critics and our greatest assets.

Meet our 1981 Pharmacy Consultant Panel.



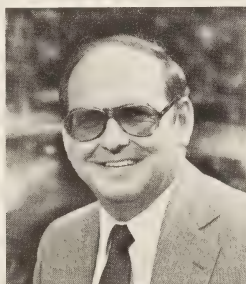
H. Joseph Schutte, R.Ph.
Community Pharmacist
Louisville, Kentucky



Louis M. Sesti, R.Ph.
Executive Director
Michigan Pharmacists Association
Lansing, Michigan



Milton H. Miller, R.Ph.
President, Petty Drug Company, Inc.
Little Rock, Arkansas



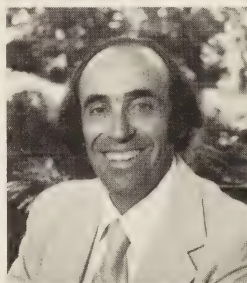
Gary Thudium, R.Ph.
Community Pharmacist
Vinton, Iowa



Martin Lambert, Ph.D., R.Ph.
Community Pharmacist
Knoxville, Tennessee



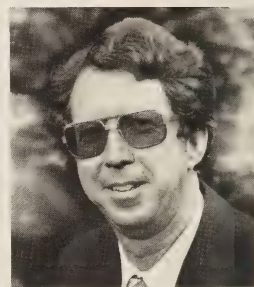
Marianne Ivey, R.Ph.
Clinical Pharmacist
University of Washington Hospitals
Seattle, Washington



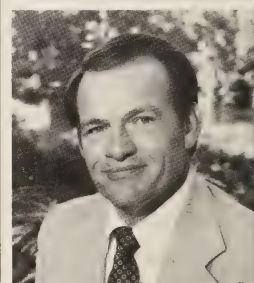
Harold H. Wolf, Ph.D., R.Ph.
Dean, College of Pharmacy
University of Utah
Salt Lake City, Utah



Paul Burkhart, R.Ph.
Director of Pharmacy
University of Maryland Hospital
Baltimore, Maryland



Harland W. Henry, R.Ph.
Director of Pharmacy
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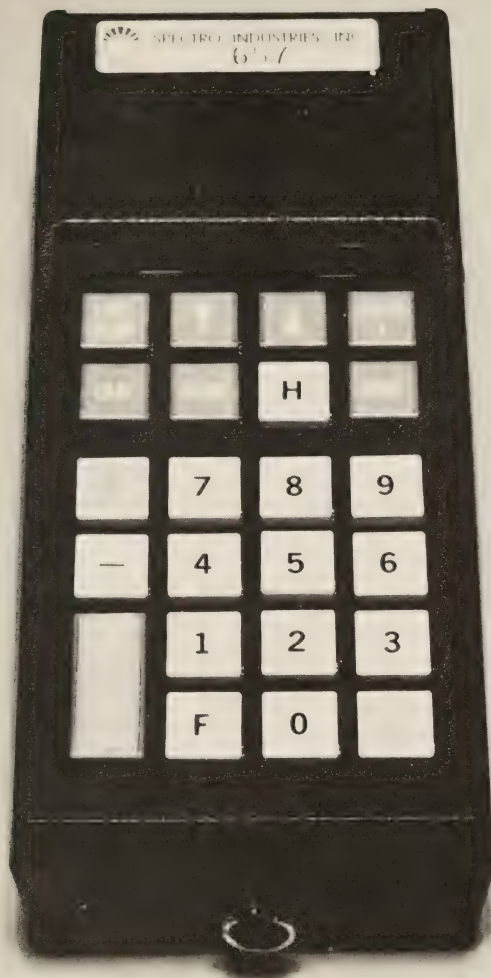
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APhA

DMSO

The American Pharmaceutical Association (APhA) has warned that pharmacists who sell, distribute or promote DMSO (dimethylsulfoxide) for therapeutic use other than as an approved prescription drug are in gross violation of the Association's Code of Ethics.

This decision was announced by the Judicial Board of the American Pharmaceutical Association, the national professional society of pharmacists with 55,000 members.

DMSO is an industrial solvent which has been promoted in the media for therapeutic uses not yet cleared for safety and effectiveness by the Food and Drug Administration. Currently, the interstate marketing of DMSO as a non-prescription drug is illegal. FDA has approved the use of pharmaceutical-grade DMSO as a prescription drug for symptomatic relief of interstitial cystitis.

"This approved indication has created only a minimal demand for DMSO as a drug. However, the claimed use of DMSO for other therapeutic purposes, particularly for the relief of arthritic conditions, has been widely publicized," the Judicial Board opinion said. It added that widespread publicity has created a demand for DMSO by those seeking such claimed therapeutic benefits.

"It is only reasonable to expect that persons seeking DMSO from a pharmacist without a prescription order, particularly persons having no apparent non-drug use for the substance, plan to use it as a drug for anticipated therapeutic purposes," the opinion said.

The Judicial Board pointed out that the safety and effectiveness of DMSO as a human drug has not been established by FDA other than for use for symptomatic relief of interstitial cystitis.

The Judicial Board warned that there is current evidence of a risk of toxicity to individuals from certain forms of DMSO application or administration.

Three sections of the American Pharmaceutical Association's Code of Ethics state that pharmacists should hold the health and safety of patients to be a first consideration; that they should never knowingly condone dispensing, promoting or distributing drugs that do not meet standards required by law and that lack therapeutic value; and that pharmacists have a duty to observe the law.

"The Judicial Board advises that a pharmacist selling, distributing, or promoting DMSO over-the-counter, having reason to know that the substance is intended to be used for therapeutic purposes in a human when its safety and effectiveness as a non-prescription drug has not been approved by the FDA, is in gross violation of the three provisions of the APhA Code of Ethics . . .", the opinion said. "The Judiciary Board believes that such conduct by pharmacists is reprehensible and deserving of the most rigorous condemnation."

JUDICIAL BOARD ADVISORY OPINION 1-81

Pharmacists' Distribution or Promotion of Dimethylsulfoxide (DMSO)

Is it ethical for a pharmacist to sell, distribute, or promote dimethylsulfoxide (DMSO) over-the-counter if the substance is labeled only as a solvent and possible therapeutic use is disclaimed?

The Judicial Board is of the opinion that a pharmacist's sale, distribution, or promotion of DMSO, other than in a prescription-legend drug product, is a gross violation of the APhA Code of Ethics, even if the substance is labeled only as a solvent and therapeutic use is disclaimed.

Pharmaceutical-grade DMSO has a single current labeling indication for medical use in humans that is approved by the Food and Drug Administration. The drug is a prescription-legend preparation and the approved indication is for symptomatic relief of interstitial cystitis. This approved indication has created only a minimal demand for DMSO as a drug. However, the claimed use of DMSO for other therapeutic purposes, particularly for the relief of arthritic conditions, has been widely publicized. Attention has been drawn to DMSO in both the broadcast and print media and, as might have been expected, publicity has created a demand for the substance by individuals seeking such claimed therapeutic benefits. It is only reasonable to expect that persons seeking DMSO from a pharmacist without a prescription order, particularly persons having no apparent non-drug use for the substance, plan to use it as a drug for anticipated therapeutic purposes.

The safety and effectiveness of DMSO as a human drug has not been established by the FDA for any indication other than that stated above. Moreover, at the time this Advisory Opinion is issued, FDA has not approved the interstate marketing of DMSO as a nonprescription drug. Further, there is current evidence of significant toxicity to individuals from certain forms of DMSO application or administration.

There has come to the attention of the Judicial Board significant information indicating that some pharmacists have been involved in the promotion, sale, or other distribution of DMSO to lay persons without a prescription order knowing that the substance is being obtained for intended human therapeutic use. DMSO has, in fact, been publicly promoted by some pharmacies which state in their

ISSUES OPINION

advertising that the substance is available over-the-counter only as a solvent or which disclaim any therapeutic use for it — but with a clear implication that the substance can be used in that manner. The Judicial Board views these statements and disclaimers as an obvious sham. For example, one piece of pharmacy advertising, while affirmatively disclaiming therapeutic use, highlights media publicity regarding DMSO which focused on its claimed therapeutic use in the relief of arthritic conditions.

The APhA Code of Ethics provides ample guidance on this matter. Section 1 of the APhA Code of Ethics states:

"A pharmacist should hold the health and safety of patients to be a first consideration and should render to each patient the full measure of professional ability as an essential health practitioner.";

Section 2 of the APhA Code of Ethics provides further:

"A pharmacist should never knowingly condone the dispensing, promoting, or distributing of drugs or medical devices, or assist therein, that are not of good quality, that do not meet standards required by law, or that lack therapeutic value for the patient.";

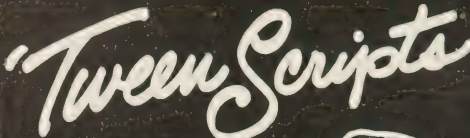
And, Section 4 of the APhA Code of Ethics holds that:

"A pharmacist has the duty to observe the law, to uphold the dignity and honor of the profession, and to accept its ethical principles. A pharmacist should not engage in any activity that will bring discredit to the profession and should expose, without fear or favor, illegal or unethical conduct in the profession."

The Judicial Board advises that a pharmacist selling, distributing, or promoting DMSO over-the-counter, having reason to know that the substance is intended to be used for therapeutic purposes in a human when its safety and effectiveness as a nonprescription drug has not been approved by the FDA, is in gross violation of the three provisions of the APhA Code of Ethics, as quoted above.

The Judicial Board believes that such conduct by pharmacists is reprehensible and deserving of the most rigorous condemnation. By this advisory Opinion, the Judicial Board seeks to express such condemnation to the profession and the public.

W. Allen Daniels
Jerry D. Karbeling
Kathryn L. Nygren
Robert L. Snively
James N. Tyson



By Jake Miller, Pharmacist
Manager, Professional Relations
A. H. Robins Company, Inc.



Professionalism and the self-medicating patient...

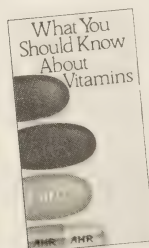
My grandfather used to say that you can learn a lot about a man's character by looking at the books on his shelves. The same idea applies to our profession. You can learn a lot about a pharmacist's professionalism by looking at the products on his shelves.

If pharmacists want to maintain their sense of self-worth and their professional image, they should pay special attention to the quality and the kinds of non-prescription medications they offer to the public. This demands that each new product be given a simple and straightforward evaluation. Are you confident that the claims contained in the labeling of the product are justified based on your knowledge of the ingredients and the conditions for which the product is claimed to treat? Is the advertising and promotion for the product truthful and fair? Does it overstate claims and expected benefits of use? Finally, has your own past experience shown that you can rely on what the manufacturer says about his product?

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Your A. H. Robins representative will be contacting you soon to discuss your fall and winter needs for Allbee® with C, Allbee® C-800, Allbee® C-800 plus Iron and Z-BEC®. Ask your representative for copies of the point of sale brochure titled "What You Should Know About Vitamins". You'll find it useful in helping the self-medicating patient choose the right vitamin formulation.



Jake Miller

A-H-ROBINS

A. H. Robins Company
Richmond, Virginia 23220



Once again, the MPhA participated with the Poison Control Center, Student Committee on Drug Abuse and the Elder Ed Program at the School of Pharmacy to present a display at the 1981 Consumer Awareness Expo. Here Annette Byers distributes literature to an interested consumer.



For three days, consumers received information about the activities of the cooperating pharmacy organizations as the booth was manned by volunteers. Jacquie Lucy (left) and Eilene Harris (back to camera) are ready to assist one of the many individuals who learned about Pharmacy activities in Maryland through the booth.



MPhA President Phil Cogan enjoys the crabs at the Annual Upper Bay Pharmaceutical Association Crab Feast.



The Crab Feast was held on August 16th and attracted the largest crowd in recent years to enjoy the crabs, swimming and softball.

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The School of Pharmacy Elder-Ed Program pairs students and senior pharmacists to visit senior centers, churches, etc. to promote consumer drug education for Maryland's senior citizens.

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must enjoy helping to bridge the gap between the "young" and the "old"

HOURS:

as desired

SALARY:

payment in gratitude and good-will

FRINGE BENEFITS:

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****This program has received the Certificate of Recognition as Baltimore's Best and the State Office on Aging Certificate of Appreciation.**

JOIN US! For a coffee and cake reception. Find out more about the program. Meet other pharmacists who have been working with us.

DATE: Wednesday, November 18, 1981

TIME: 10:30 AM

PLACE: Maryland Pharmaceutical Assoc.
650 W. Lombard St., Baltimore

RSVP: Call 528-3243

Perspectives in Pharmacy

Capitation*— Reimbursement for Pharmacy Services

Presented
in the interest of
better-informed
pharmacy.

*Capitation is a system of payment by which a provider receives a fixed amount for services rendered each person for a given time period, usually a month.

Jean Paul Gagnon, R.Ph., Ph.D.
Professor, Pharmacy Administration
School of Pharmacy
University of North Carolina at Chapel Hill

"Capitation is not new to pharmacy. As early as 1969, this system of payment was being discussed as a reimbursement method for pharmacy services.

"There are theoretical advantages to pharmacists being paid a fixed monthly rate per patient:

- service and administrative costs could be lowered;
- pharmacists would be able to consider patient needs first;
- pharmacists could keep abreast of current drug therapies and technology;
- greater continuity of patient care could be provided;
- utilization of high-cost services could be lowered;
- more extensive preventive health efforts could be made;
- and more favorable health outcomes might result.

"On the other hand, capitation may stimulate providers to:

- devote fewer hours to patient care;

- refer patients to other facilities more readily;
- be more inflexible and less responsive in dealing with patients;
- screen potential enrollees for health status;
- place profit before services;
- and delay or prolong services.

"There is little documentation to support either the advantages or the disadvantages of capitation to the pharmacy profession. Because its use so far has been limited, capitation needs additional evaluation before a decision concerning its utilization can be made.

"In the long run, after pharmacists have realized 'windfall profits' through implementation of such cost-saving strategies as generic substitution and use of OTC drugs, capitation may be attended by the same problems as the fixed-fee

method. It is likely that, in times of tight money, legislators and program administrators would exhibit the same attitudes about capitation as they currently do toward fixed professional fees—they will be tempted to minimize costs by not raising the capitation rate. In fact, because of 'windfall profits' that will be generated in the early years of the capitation approach, state legislators will probably tend to reduce the rate. At the very least, pharmacists will be asked by legislators to justify rate increases by conducting cost studies of their operations.

"There is as much controversy today about third-party reimbursement for pharmacy services as there was in 1968. Because of federal antitrust laws and the lack of consensus on the part of pharmacists, pharmacy organizations have been unable to convince program administrators of the value of their services and the advantages of competitively determined prices as opposed to a cost-plus approach. In the final analysis, the capitation approach may serve only to delay solution of the reimbursement problem."

Raymond A. Gosselin, R.Ph., Sc.D.
President, Massachusetts College of Pharmacy
and Allied Health Sciences

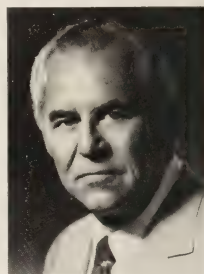
"Subjective appraisals of the capitation system are apt to be inconclusive in the short term, because, initially, there would seem to be some advantages, e.g., money up front, no claim forms, etc. But, at some point, pharmacists will have exhausted all opportunities to hold down costs by substituting less expensive drugs, eliminating refills, curtailing overuse, and switching patients to home remedies. Meanwhile, increasing amounts for rent, light, heat, taxes, and the like will have to be paid.

"Program administrators, faced with the need to eliminate the 'fat' from budgets and aware that pharmacists retain any amount left from the initial capitation fee that is not spent on program recipients, would inevitably cut successive annual funding.

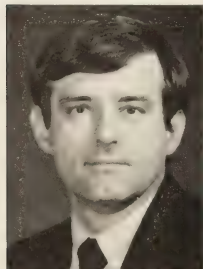
"The bottom line of any proposed capitation system would not be in savings realized by curtailing overuse or by switching patients from prescription drugs to over-the-counter ones but in using less expensive generic drugs. The capitation system, in effect, would be no more than a mechanism for forcing the use of the cheapest drugs available. Making a choice based on price as the sole criterion does not involve professional judgment. Under a capitation system, pharmacists would have to resort to the lowest-priced drugs in order to remain in business.

"As long as pharmacy remains a predominantly private enterprise in this country, and there is little to indicate otherwise, incentives for providing new and better services—including patient consultation and monitoring—need to be positive rather than negative. New activities for pharmacists must be justified in terms of building clientele, increasing volume and business, and earning a reasonable profit.

"Pharmacists can play a major cost-saving role in health care by helping people get well and stay well by means of the proper application of efficacious drug therapy. Billions can be saved in physicians' fees, hospitalization costs, diagnostic tests, and the like by aggressive and positive application of pharmacists' skills. Such expertise is valuable, and pharmacists should be paid for their contribution. The cost of such services is indeed small in relation to the genuine savings in total health care that can be realized."



Raymond A. Gosselin, R.Ph., Sc.D.



Jean Paul Gagnon, R.Ph., Ph.D.



Eli Lilly and Company
Indianapolis, Indiana 46285

The views expressed are the authors' and not necessarily those of Eli Lilly and Company.

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BOB BERGSTEIN

JON JOHNSON

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Dog work: counting inventory, filing, keeping up-to-date price lists: that's not what we went to school for. But it takes up too many hours in a pharmacist's day. Bob Bergstein and Jon Johnson of the Clinton Pharmacy, Clinton, MD, found the answer in the IBM QS/1 System.

Jon Johnson says, "Our Medicaid volume runs in excess of \$10,000 per month, and the turn-around time from submission to cashing of the check has been cut from 34 to nine days. Our Aetna payments are now paid within days against the old system which took almost two months. At 2% a month, the interest on that money alone almost justifies the cost of the machine."

Bob Bergstein concurs. "The QS/1 posts charges and third party plans automatically; prices prescriptions; prints labels — it takes only three seconds to print a refill label," Bob notes.

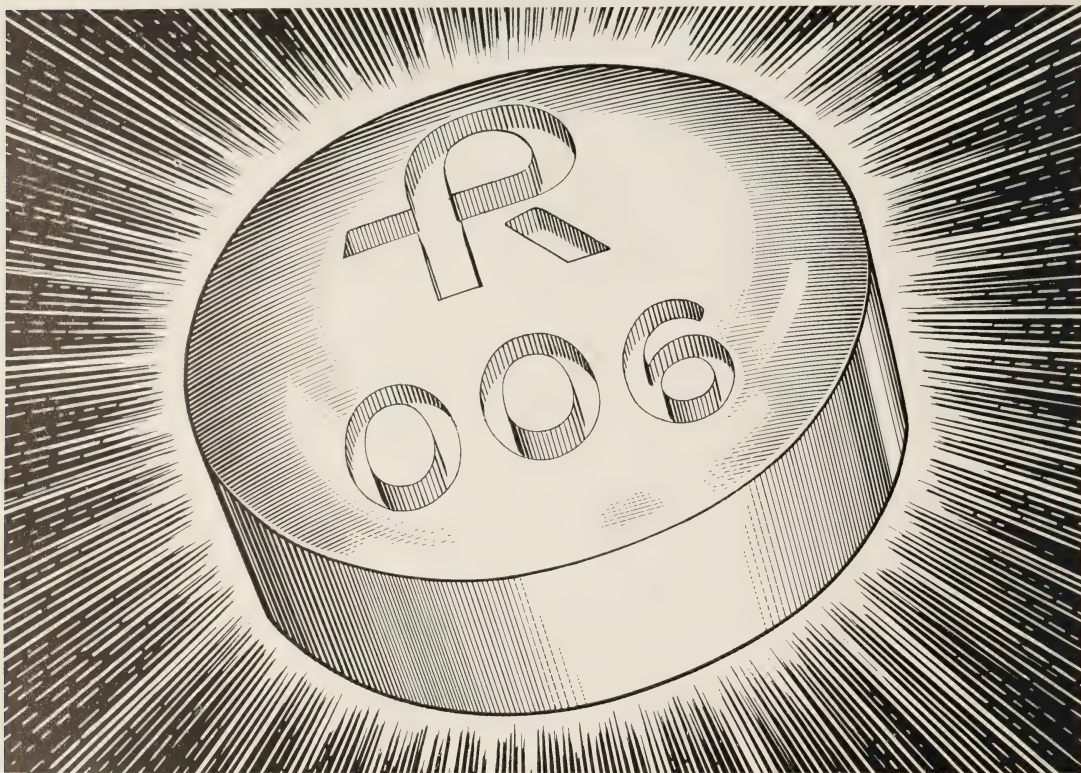
Call Jon Johnson or Bob Bergstein at the Clinton Pharmacy, (301) 868-2000. They'll give you a free demonstration of the QS/1 on the job. It's easy to lease. Now's the time.

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Will your generics need a lawyer?

Beware! Many state laws, now in effect or proposed, require the identification of product, strength and manufacturer on each solid doseform to be legal for generic substitution. If you dispense unidentified drugs, after effective date of legislation, you're dispensing in violation of such laws.



Purepac generics coded for legal substitution.

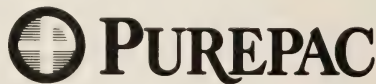
Purepac's coding system, to be phased in during 1981, will meet every state's legal requirements. Tablets and capsules will be imprinted with a code number and Purepac's symbol. This symbol **R** identifies a Purepac product. The code number designates the name of the product and its strength. For rapid identification, these code numbers will be listed in Purepac's catalog and the *Physician's Desk Reference*. This system provides instant identification which can prove useful in saving lives from accidental overdose.

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Will your generic pharmaceutical supplier be able to meet all identification requirements—especially if that

supplier is not a manufacturer? Products not properly coded then violate the law! And by dispensing them, you're substituting illegally. And taking big risks.

Don't take chances. Be sure you're dispensing a legal generic. Be sure it's Purepac!



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Edgewater, Md 21037 Severna Park, Md 21146

ALLEGANY-GARRETT CO PHARMACEUTICAL ASSN. (June to June)

Pres: C. Dennis Elliott, Jr. Secy: Mrs. Rose Marie Smith
P.O. Box 252 39 Hilltop Road, Bel Air
Frostburg, Md 21532 Cumberland, Md 21502

BALTIMORE METROPOLITAN PHARMACEUTICAL ASSN. (November to November)

Pres: Joseph Loetell Secy: David A. Banta
9301 Montego Ave 650 W. Lombard St
Balto, Md 21234 Balto, Md 21201

EASTERN SHORE PHARMACEUTICAL SOCIETY (January to January)

Pres: Joseph Ras Secy: Vincent Gattone
RD #4, Box 274 Edgemere Rd, Rt #4, Box 354
Chesterstown, Md 21620 Easton, Md 21601

PRINCE GEORGES-MONTGOMERY COUNTY PHARMACEUTICAL ASSN. (September to September)

Pres: Stanton Brown Secy: Cathy Schumaker
26 Cory Terrace 16629 Cashell Rd
Silver Spring, 20902 Rockville, Md 20853

UPPER BAY PHARMACEUTICAL ASSOCIATION (September to September)

Pres: Cynthia Boyle Secy: Bob Plummer
3336 Level Rd P.O. Box 64
Churchville, Md 21028 Aberdeen, Md 21001

WASHINGTON COUNTY PHARMACEUTICAL ASSN.

Secy: Frederick Fahrney
8 Hampton Rd, East
Williamsport, Md 21795

FREDERICK COUNTY PHARMACEUTICAL ASSN. (established July 16, 1981)

Fraudulent Prescriptions pictured here

To cut down on fraudulent prescriptions, the *Mt. Lebanon, Pa.* (pop. 37,769), police department has purchased six document transaction cameras, the type that photographs the subject and document simultaneously. These cameras are placed in the drug stores at the owner's request so that suspected fraudulent prescriptions offered to them can be challenged. Regular customers are not offended or bothered; only the suspect prescription passer is asked to pose before the prescription is filled.

This project began in January, 1979, when a survey was mailed to thirteen communities surrounding Mt. Lebanon asking if they were experiencing the problem of fraudulent prescriptions. Twenty of the forty stores responded that approximately 360 fraudulent prescriptions were offered at each store annually (approximately one per day). Each pharmacist indicated a desire for assistance if it did not entail bureaucratic paperwork or long court time.

On September 22, 1979, six stores had operational programs. After seventeen months, records indicated the problem was reduced to only ten fraudulent prescriptions per store and several arrests have been made. Although the problem is not 100 percent solved, it is considered under control. A secondary benefit is the reduction of shoplifting and armed robbery opportunities by keeping the drug abusers out of stores and the community. For further information, contact Supervisor William L. Rieg, Mt. Lebanon Police Department, 710 Washington Road, Mt. Lebanon, Pa., 15228, 412-343-3400, ext. 249.



American Heart Association (Maryland Affiliate) Board Chairman David Fedder (middle) presents the Community Service Award to MPhA Past President Donald O. Fedder at the American Heart Association annual Meeting. Fedder was recognized for his work as Vice-Chairman of the Maryland High Blood Pressure Coordinating Council and as Chairman of its Pharmacy Committee.



Paul Burkhardt, (center), Director of Pharmacy, University of Maryland Hospital, Baltimore, recently attended the annual meeting of the Upjohn Pharmacy Consultant Panel at Brook Lodge, near the company's Kalamazoo, Mich. headquarters. The panel includes 10 pharmacists in a variety of pharmacy disciplines from around the U.S. who gather annually to discuss pharmacy topics with Upjohn officers and marketing personnel. During the meeting, Burkhardt met with Louis C. Schroeter (left), Vice President and General Manager, Domestic Pharmaceutical Division, and Reed B. Peterson, Vice President, Domestic Pharmaceutical Marketing.

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

INTERFERON:

Crude human leucocyte interferon was injected in 14 patients with advanced tumor growth. Injections of the crude preparation were made into the tumors themselves or into adjacent tissues. One woman with advanced stages of breast cancer died of problems associated with distant metastases, but the rest of the study group have been free of symptoms for from 3 to 30 months following the six-month treatment program. *LANCET*, Vol. I, #8228, p. 1822, 1981.

ADIPOSE TISSUE LIPOPROTEIN LIPASE:

The activity of an enzyme located in fat tissue is thought to be at least partially responsible for the weight which is regained after it has been lost through dieting. Only 5% of patients who have lost weight have not regained it back within 3 to 5 years. This suggests that some basic biochemical mechanism has not been corrected by the weight reduction process. It is postulated that since adipose tissue lipoprotein lipase activity remains high even after the initial weight loss, it is responsible for the fat deposition which occurs after the initial period of weight reduction. *J CLIN INV*, Vol. 67, #5, p. 1425, 1981.

ANTIBIOTIC THERAPY IN CANCER PATIENTS:

Infections in cancer patients represent the major cause of death in this population group. Patients with acute leukemia were treated either with cotrimoxazole (Bactrim, Septra) and nystatin or with gentamicin (Garamycin) and nystatin. Both regimens seemed to work well, but the combination of cotrimoxazole and nystatin was less toxic and patient compliance was better. *N ENG J MED*, Vol. 304, #18, p. 1057, 1981.

MONOAMINE OXIDASE INHIBITORS:

Researchers have re-investigated the possibility that monoamine oxidase inhibitors may be useful in treating anxiety reactions in humans. Data suggest that these drugs may be most useful in treating patients with severe or chronic phobias and/or panic disorders. Some clinicians feel that it is not inappropriate by current standards for psychiatrists to use monoamine oxidase inhibitors to treat patients with severe or refractory conditions. *J AM MED A*, Vol. 245, #18, p. 1799, 1981.

NIFEDIPINE:

Nifedipine is a new agent which may be approved for general use before too long. The drug was found to be effective in treating angina which occurs at rest, especially that which has been found to be refractory to propranolol and nitrates. It is said to be especially useful in treating patients with obstructive coronary artery disease. *ANN INT MED*, Vol. 94, #4, p. 425, 1981.

ARTHRITIS:

It has been postulated, but not proven, that the inflammatory effects of antiarthritic agents is dependent on the ability of the drug to penetrate the synovial fluid. Ibuprofen (Motrin) was administered to volunteers and samples of the drug in the plasma and in the synovial fluid were analyzed. It was found that the amount of drug which penetrates the synovial membrane is directly dependent on the amount of free drug found in the plasma. *CLIN PHARM*, Vol. 29, #4, p. 487, 1981.

THEOPHYLLINE AND METHADONE:

Theophylline is capable of stimulating respiratory function while methadone produces the opposite effect. Both agents were administered to dogs to determine if they acted on the same receptor site in the brain. It was concluded that theophylline decreases the threshold of the central chemoreceptor to the presence of carbon dioxide and thus respiration increases. On the other hand, methadone decreases sensitivity of these areas and respiration slows. However, the exact site of the central receptors affected by each drug seems to be anatomically different. *J PHARM EXP*, Vol. 217, #2, p. 278, 1981.

ANTICONVULSANT THERAPY:

Once therapy has been initiated because a convulsion has occurred, it may be continued indefinitely because there have been no guidelines suggested as to when therapy should be stopped. In efforts to make a decision to discontinue therapy more scientific, a study was conducted in 68 children who had been given anticonvulsant therapy. The authors of the study have concluded that the best candidates for having therapy discontinued are those who have had four seizure-free years, have no other medical problems, and have normal or only mildly abnormal electroencephalographic tracings. *N ENG J MED*, Vol. 304, #19, p. 1125, 1981.

DIAZEPAM METABOLISM:

Patients receiving antitubercular therapy consisting of isoniazid, ethambutal and rifampin were noted to have lower-than-predicted plasma levels of diazepam (Valium). Closer investigation of the individual components of the triple therapy showed that isoniazid inhibited the clearance of the minor tranquilizer, but this activity was masked overwhelmingly by the enzyme-inducing capacity of rifampin. This ultimately resulted in shortening the half-life of the benzodiazepine derivative during triple therapy. The doses of diazepam may need to be adjusted accordingly in patients receiving therapy for tuberculosis. *CLIN PHARM*, Vol. 29, #5, p. 671, 1981.

CALCIUM:

Isoproterenol (Isuprel) has the ability to stimulate glycolysis in skeletal muscle by activating cyclic AMP. Studies conducted in animals has produced data which suggest that calcium may act in a regulatory role by reducing the amount of cyclic AMP formed. Verapamil reversed the effect of calcium and the effectiveness of calcium in this system was found to be augmented by the presence of cobalt, nickel, and manganese ions. *J PHARM EXP*, Vol. 217, #2, p. 271, 1981.

GUANADREL:

A new antihypertensive agent similar to guanethidine (Ismelin) was tested in 199 hypertensive patients. The drug, guanadrel, was found to be effective in reducing blood pressure at all levels. It has a rapid onset and a short duration of action, thus making the incidence of side-effects minimal. The drug produces no central nervous system effects and should be considered when a Step II or Step III drug is required to control hypertension. Guanadrel is to be sold under the trade name Hyloril. *J AM MED A*, Vol. 245, #16, p. 1639, 1981.

GASTRIC JUICE ANALYSIS:

The analysis of gastric juice for enzyme content may be a useful way to identify patients with gastric cancer. The measurement of lactic dehydrogenase and beta glucuronidase in gastric juice has provided investigators with a way to predict the presence of this cancer. Results were positive in 41 of 42 patients tested. *LANCET*, Vol. I, #8230, p. 1124, 1981.

MINAXOLONE:

A new steroidal anesthetic agent has been used experimentally and was found to be an effective agent yet relatively free of side-effects. The drug, minaxolone, was noted not to alter the activity of the cardiovascular system when given in normal doses although excessive amounts of it produced stable hypotension and decreased cardiac output. More work will be completed to determine if the drug has market potential in this country. *J PHARM EXP*, Vol. 217, #2, p. 481, 1981

ALPHA ADRENERGIC RECEPTORS:

Research conducted in dogs has indicated the presence of alpha adrenergic receptors in the smooth musculature of the airway. In addition, two subtypes of alpha receptors have been identified in the post synaptic area. Alpha-1 receptors are activated by phenylephrine (Neosynephrine), resulting in broncholar constriction. Clonidine (Catapres) stimulates the alpha-2 receptors while norepinephrine activates both types. Activation results in contraction of the smooth muscle. Although these receptors seem to be present and functional, the control of the smooth muscle in respiratory tissue is primarily under beta-adrenergic control and the alpha stimulation demonstrated in this experiment was evident only when the beta-adrenergic activity had been blocked by beta-adrenergic blocking agents. *J PHARM EXP*, Vol. 217, #2, p. 530, 1981.

PREMATURE INFANTS:

Premature infants have a greater than average risk of early death. It has been difficult to predict the likelihood of death in these children, but now a technique has been developed which can be used successfully to determine the status of the premature child. Investigators utilize ultra sound to scan the brain of these children and can take the information from that scan and accurately predict their likelihood of survival. The degree to which the brain has developed seems to be a good indicator of risk. *LANCET*, Vol. I, #8230, p. 1119, 1981.

SULFASALAZINE:

Some patients have difficulty tolerating the oral administration of sulfasalazine (Azulfidine). They experience nausea, abdominal discomfort, and headaches. The drug was prepared in an enema form and was administered to patients with ulcerative colitis. Seventy percent of those patients responded positively to this form of the drug while only a few experienced any relief from the placebo preparation. Patients receiving the sulfasalazine enemas experienced no side-effects and thus this method of drug administration may be of significant value in treating patients with ulcerative colitis who cannot tolerate oral administration. *BR MED J*, Vol. 282, #6276, p. 1571, 1981.

CHIRIQUITOXIN:

Much of the information currently available concerning ionic transport through cellular membranes was accumulated with the aid of a substance called tetrodotoxin. It acted to specifically bind to the sodium channels on the cell membrane, thus preventing the initial phase of cellular depolarization. A new substance, named chiriquitoxin, has been found to block both the sodium and potassium channels on the cell surface. The compound, an analog of tetrodotoxin, was used to map the distance between the sodium and potassium channels on the membrane. It appears that the pores are not less than 5 Angstroms nor more than 15 Angstroms apart. *J PHARM EXP*, Vol. 217, #2, p. 416, 1981.

PULMONARY HYPERTENSION IN CHILDREN:

Children who experience symptoms of sleep disturbances and snoring may have pulmonary hypertension. This is often associated with enlargement of the tonsils and adenoids, but in several instances, children have experienced complications during surgery because of the pulmonary hypertension. A prospective study was designed to study children prior to having their tonsils and adenoids removed. Children who experienced sleep disturbances and snoring were found to often have pulmonary hypertension and the authors of this article suggest that children who snore be examined to determine if there are underlying pathologies which might not initially be obvious. *BR MED J*, Vol. 282, #6276, p. 1579, 1981.

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- Notification for the patient under the Drug Product Selection Law
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- The Association's Employment Clearinghouse, helping pharmacists and employers find one another
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- Information on the NEW USP/NF on sale from MPhA
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- I have a supply of Nicalax tablets which have been discontinued.

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Every Sunday Morning at 6:30 a.m. on WCAO-AM and 8:00 a.m. on WXYZ-FM, listen to Charles Spigelmire broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore.

The Elder Ed Program at the University of Maryland School of Pharmacy has a new consumer pamphlet available entitled "The Care Giver's Medication Guidelines." The information presented is valuable to an individual who cares for an elderly family member or friend. For information contact: the Elder Ed Program, U. of Md. School of Pharmacy, 636 W. Lombard St., Baltimore, Md. 21201.

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Baltimore, Md. 21201

The University of Maryland School of Pharmacy is interested in including 4 antique pharmacy fixtures in its new building, planned for completion in 1983. Anyone interested in such an idea is invited to call the Dean's Office, 528-7650.

calendar

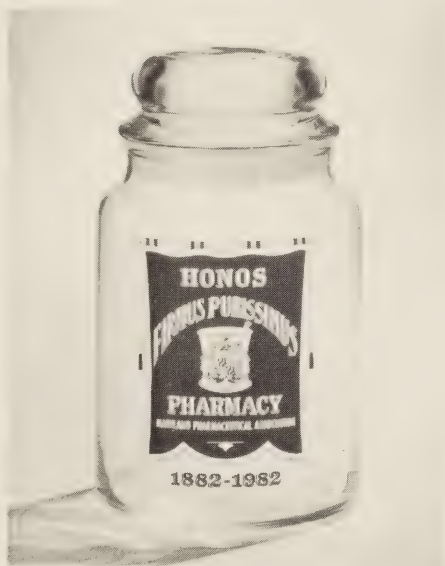


- Oct. 11 — MPhA Dinner Theatre at Tobey's
- Oct. 11 — AZO Kappa Breakfast Meeting, 10 a.m. Holiday Inn Pikesville
- Oct. 18 — Alumni Association Oyster Roast — Overlea Hall
- Oct. 30 — MPhA Oriental Odyssey — 14 night trip
- Nov. 15 — Seidman Memorial Seminar — Pulmonary Disease — BWI Airport Hotel
- Jan. 11-18 — MPhA Trip to Cancun — For Winter Sun and Fun
- Feb. 14 — Baltimore Metropolitan Pharmaceutical Association Dinner
- April 24-29 — APhA Convention, Las Vegas
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- April 24-29 — APhA Convention, Las Vegas
- June 20-24 — MPhA Centennial Convention — Ocean City

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To commemorate its 100th anniversary celebration, the Maryland Pharmaceutical Association is issuing a special edition, custom designed apothecary jar. For a limited time only, members and friends are invited to purchase these deluxe containers in recognition of the association's first century of service.

Each glass jar is imprinted with a two-color reproduction of the Maryland Pharmacy banner and the words: "Honos, Firmus, Purissimus — Pharmacy, the Maryland Pharmaceutical Association — 1882-1982." The jars are suitable for home or office because of their wide variety of uses:



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THE MARYLAND PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

November, 1981
VOL. 57
NO. 11



The Doctor of Pharmacy Program

— Gary Oderda, Pharm.D.

Keep Pointed Toward Profit

— Jack Feller, Jr.

NDC Reference Chart

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Hotline for impaired Dentists (301) 796-8441

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
TELEPHONE 301/727-0746



NOVEMBER, 1981

VOL. 57

NO. 11

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You will recall that the MPhA House of Delegates passed a resolution at the 1981 convention to seek graduate home study and/or part-time classroom coursework geared to the practicing pharmacist. Obviously, the average pharmacist cannot adjust his or her schedule to accommodate the rigors of the curriculum of day classes at the University of Maryland School of Pharmacy. If there is truly interest in the program on behalf of both the School and the profession we can further the dialogue. Dean William Kinnard of the School of Pharmacy has indicated that he would be receptive to our views in this area. The ball is in the practitioners' court to describe what the program would entail and the degrees to be obtained. With sufficient practitioner interest, the School will take it from there.

I'm glad that we have been asked for our input for a part-time graduate program. I would like to see the invitation extended to the undergraduate program. There is a need for practitioner involvement in curriculum development and on the faculty. This should go beyond the PEP preceptor program. The School does have a very realistic undergraduate curriculum and we would like to offer our assistance to help keep it that way. Other schools of pharmacy have become so research oriented that they are losing touch with the practitioners. I would hate to see the University of Maryland School of Pharmacy drift away from where it is. Other professions have their practitioners present coursework extensively. Traditionally, pharmacy has not done this.

The Association enjoys its relationship with the School of Pharmacy and appreciates the contributions that the School provides to the profession. The profession now stands ready to contribute to the School.

Philip H. Logan,
PRESIDENT

UNIVERSITY OF MARYLAND

THE DOCTOR OF PHARMACY PROGRAM

by
Gary Oderda, Pharm.D.

The faculty of the University of Maryland School of Pharmacy recently voted to expand the Pharm.D. program from six to ten students. This will allow the School to admit additional students while maintaining a small class size that will enable providing a great deal of individual attention as well as a significant amount and wide variety of clinical experience. Because of the recent increase in class size and the fact that many pharmacists in the state are not knowledgeable about the program, the decision was made to describe the program in the *Maryland Pharmacist*.

The University of Maryland Doctor of Pharmacy Program is a two year program leading to the Pharm.D. degree. The major emphasis of the program is to train clinical pharmacists. The program draws on resources from the University of Maryland at Baltimore Campus as well as clinical sites throughout Maryland. A small class size allows for significant individual attention as well as a significant amount and wide variety of clinical experience.

Goal

The Doctor of Pharmacy program is designed to provide advanced scientific and clinical knowledge, advanced patient care skills, and attitudes which will allow the graduate to function as a clinical pharmacist; i.e., a therapeutic consultant, a direct provider of health care, a patient educator and a health professional educator in the clinical use of therapeutic agents.

Program Objectives

Upon completion of the program, the Doctor of Pharmacy graduate will be able to:

1. Define and assess patients' therapeutic problems utilizing selective clinical data, including patient history and physical assessment skills.
2. Define achievable therapeutic objectives and identify and monitor discriminating subjective and objective end points of therapy.
3. Identify appropriate drug variables and appropriate patient variables and integrate these variables into optimal therapeutic regimen design.
4. Identify toxic end points of drug use and actively monitor those end points to prevent development of predictable toxic responses.

5. Detect, assess, and appropriately manage adverse drug reactions.
6. Identify, assess, and provide information in the management of toxic ingestions and play an active role in poison prevention.
7. Assume primary responsibility in ambulatory chronic disease management and primary health care.
8. Conduct implicit and explicit therapeutic audits in areas of both ambulatory and inpatient care.
9. Function as a clinical health professional educator with ability to define specific educational objectives, utilize educational methodologies, and utilize appropriate student evaluation techniques.
10. Identify patient education needs and develop and implement patient education plans.
11. Retrieve, evaluate and interpret appropriate scientific and clinical literature to provide clinically relevant drug information.

Program Content

The Doctor of Pharmacy Program is a two year program leading to the Pharm.D. degree. The curriculum spans three major areas: didactic coursework, clinical education and pharmacy practice.

1) Didactic Coursework: didactic coursework includes: therapeutics, clinical toxicology, advanced biopharmaceutics, statistical methods in clinical investigation, drug induced diseases, physical diagnosis and the elective, drug utilization and medical audit. Seminar courses are generally interdisciplinary with input from both basic science and clinical faculty. Seminar courses include drug and clinical faculty. Seminar courses include drug action, clinical pharmacokinetics, health educational methods, clinical therapeutics, educational methods, and advanced pharmaceutics.

2) Clinical Education: The Pharm.D. program places considerable emphasis on clinical education. Physical assessment skills are attained through the School of Medicine's course in physical diagnosis (taken in conjunction with second year medical students). Clinical experiences begin in the first semester and continue

throughout the two-year curriculum. Clinical Clerkship I is an introductory experience designed to acquaint the pharmacy student with disease states and related therapeutics, the Problem Oriented Medical Record and basic principles of monitoring drug therapy. Clinical Clerkship II students work closely with the clinical pharmacy staff in clinical services and are given some direct responsibility in patient-care services. Emphasis in these experiences is placed on gaining clinical experience, solving the practical problems in therapeutics and gaining experience in providing drug information. Clinical Clerkship III is designed to improve the depth of the students clinical skills. It also provides an opportunity for students to assume responsibility for clinical services. Initial selection of specialty areas are made at this time. Clinical Clerkship III students assume some responsibility for directing undergraduate students in their clinical clerkship.

Clerkship I (One month)	Hours
Inpatient or Outpatient Medicine	160
Clerkship II (Five Months)	
Inpatient Medicine	320
Outpatient Medicine	320
Poison Information	160
Clerkship III (Thirteen months)	
Inpatient Medicine	320
Outpatient Medicine	320
Acute Care	160
Kinetics	160
Drug Information	160
Parenteral Nutrition	160
Electives . . . Four from specialties such cardiology, infectious diseases, pediatrics, endocrinology, critical care, psychiatry, on- cology.	640
Total	2880

3) Pharmacy Practice: Students take professional experience rotations in community pharmacy practice and institutional pharmacy practice which meet the Maryland State Board of Pharmacy requirements for experience prior to licensure. Students who have a Bachelor of Science in Pharmacy prior to entry into the Pharm.D. Program can waive 160 hours of Hospital Pharmacy Practice and 160 hours of Community Pharmacy Practice if they have received equivalent professional experience.

The Curriculum

First Year	Credits
I. Summer Session (June-August)	
PPAS 368 Community Practice I*	2
PPAS 369 Institutional Practice I*	2
Total credits	4
II. Fall Session	
PCLN 461 Therapeutics (Sept-Oct.)	3
PCLN 451 Clinical Toxicology (Sept-Oct)	2
PHAR 502 Advanced Biopharmaceutics	2
PDIA 520 Intro. to Clin. Med. (Physical Diagnosis)	1

PCOL 470 Drug Action Conference	2
PCLN 570 Clinical Clerkship (Nov)	4
PCLN 578 Clinical Clerkship II (Dec)	3
PCLN 462 Statistical Concepts in Clinical Investigation	1
PPAS 449 Drug Utilization and Medical Audit (Elective)	(2)
Total Credits	18-20
III. Winter Session (January)	
PCLN 578 Clinical Clerkship II	3
Total Credits	3
IV. Spring Session	
PDIA 520 Intro. to Clin. Med. (Physical Diagnosis)	
PCOL 471 Drug Action Conference	2
PPAS 470 Health Education Seminar	2
PHAR 475 Clinical Pharmacokinetics Seminar	1
PCLN 578 Clinical Clerkship II	9
PCLN 579 Clinical Clerkship III	3
Total Credits	18
Total First Year Credits	43-45
Second Year	
I. Summer Session (June-August)	
PCLN 579 Clinical Clerkship III	6
II. Fall Session	
PCLN 580 Advanced Therapeutics Seminar I	1
PCLN 579 Clinical Clerkship III	9
PPAS 569 Institutional Practice II	2
PCLN 448 Special Projects (research)	3
PCLN 463 Drug Induced Diseases	2
Total Credits	17
III. Winter Session (January)	
PCLN 579 Clinical Clerkship III	3
PPAS 582 Educational Methods I.	1
Total Credits	4
IV. Spring Session	
PCLN 581 Advanced Therapeutics Seminar II	1
PPAS 583 Educational Methods II	1
PHAR 485 Advanced Pharmaceutics Seminar	1
PCLN 579 Clinical Clerkship III	9
PCLN 448 Special Projects (research)	3
Total Credits	15
Total Second Year Credits	44
Total Doctor of Pharmacy Credits: 87-89	
Minimum Credits for Pharm.D. as a First Professional Degree: 154	

* Required of students who have insufficient Pharmacy Experience to meet Maryland Licensure requirements.

Research

During their senior year, students must design and conduct a research project with supervision from both clinical and basic science faculty. Students are required to present their proposals and completed projects to the faculty and prepare a publishable manuscript.

Examples of Research Projects Completed by Program Graduates:

"A Protocol for the Rapid Initiation of Anticoagulation with Heparin"

"Drug Usage Review: Prescribing Practices for Cimetidine at University of Maryland Hospital"

"Iron Utilization in a Skilled Nursing Facility"

"Conversion from Intravenous to Oral Dosing Using Sustained-Release Theophylline Tablets in Hospitalized Patients"

"Nursing In-Service Education in Nursing Homes: Its Effect on Drug Therapy"

"Multi-Substance Abuse in Patients Undergoing Alcohol Detoxification and in Patients Enrolled in a Methadone Maintenance Program"

Doctor of Pharmacy Graduates

The Doctor of Pharmacy Program was initiated in September 1975. As of July 1981, five classes have completed training for a total of thirty two graduates. Graduates of the program have a variety of employment opportunities as displayed in the following table as their first graduate placement:

Area and Type of Practice	In Maryland	Out of Maryland	Totals
Residency and Fellowship			
-Pharmacokinetics	0	1	1
-Primary	2	0	2
-General Clinical	0	1	1
-Pediatrics	0	1	1
Ambulatory Care Practice			
-Institutional	1	1	2
-Psychiatric	1	0	1
-Private Practice	0	1	1
Inpatient Clinical Practice			
-Academic Affiliated	2	3	5
-Private Hospital	8	2	10
-Long Term Care	2	0	2
Pharmacokinetic Research	0	1	1
Information Services			
-General Drug	2	0	2
-Poison	1	1	2
Other	1	0	1

Because of the extensive clinical training and patient assessment skills, graduates have had considerable success in obtaining positions as practicing clinical pharmacists. It is usually recommended that graduates who desire academic faculty positions, research oriented positions or specialty practice positions (e.g. oncology, pediatrics, etc.) obtain appropriate post-doctoral training in the form of either a residency or fellowship.

Admission Requirements

Pharmacy students or graduates who have completed a pre-pharmacy and professional program equivalent to the first four years of the University of Maryland Baccalaureate Pharmacy Program (including coursework in Pathophysiology and Calculus) at an ACPE accredited pharmacy school may apply for admission to the Doctor of Pharmacy Program. *Applications must be received by January 1st and all supportive records necessary for completion of the total application must be received by January 15th.* Applications may be obtained by writing to the Dean's Office, School of Pharmacy, University of Maryland, 636 West Lombard Street, Baltimore, MD 21201.

Most admitted students have a minimum grade point average of 3.0 (on a 4.0 scale). Letters of recommendation are required of all applicants. Personal interviews are required of all students who have met the minimum criteria for admission.

Doctor of Pharmacy Program Faculty

Full-Time Academic Faculty

Department of Clinical Pharmacy
Robert A. Kerr, Pharm.D.

Chairman and Associate Professor
Dept. of Clinical Pharmacy
Associate Professor and Director

Gary M. Oderda, Pharm.D.

Maryland Poison Center
Associate Professor and Association Director, Primary Care Programs

Thomas H. Wiser, Pharm.D.

David S. Roffman, Pharm.D.

Associate Professor and Chief
Inpatient Clinical Pharmacy Service

Robert J. Michocki, Pharm.D.

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Assistant Professor
Inpatient Clinical Pharmacy Services

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Assistant Professor
Family Health Center

Wendy Klein-Schwartz, Pharm.D.

Assistant Professor and Assistant Director
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Clinical Pharmacist Consultant in Pediatrics

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Assistant Professor
Inpatient Clinical Pharmacy Services

Elaine Long, Pharm.D.

Assistant Professor
Inpatient Clinical Pharmacy Services

Barbara J. M. Zarowitz, Pharm.D.

Assistant Professor
Inpatient Clinical Pharmacy Services
Clinical Pharmacokinetics

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Assistant Director of
Pharmacy
Parenteral Nutrition
Specialist
University of Maryland
Hospital

The Campus

The School of Pharmacy is located on the Baltimore Campus of the University of Maryland. The campus is the site of six professional schools of the University. In addition to Pharmacy, the Schools of Medicine, Nursing, Dentistry, Law, and Social Work and Community Planning are present. The campus also includes the University of Maryland Hospital, the Psychiatric Institute, the Maryland Institute for Emergency Medical Services Systems, and the Baltimore Cancer Research Program.

Through the School of Pharmacy's formal interdisciplinary programs, the students participate in educational opportunities with all the professional schools and clinical programs listed above. In addition, the School has formal educational clinical pharmacy programs with most hospitals in the city including Johns Hopkins Hospital, Good Samaritan Hospital, Lutheran Hospital, Maryland General Hospital, Deaton Center for the Elderly, and the Greater Baltimore Medical Center.

For Further Information

For further information contact Gary Oderda, Pharm.D., Chairman, Subcommittee on Pharm.D. Admissions by writing to 636 W. Lombard Street, Baltimore, MD 21201 or by calling (301) 528-7604.

calendar

Nov. 15 — Seidman Memorial Seminar -Pulmonary Disease-
BWI Airport Hotel

Dec. 3 — MPhA Board Meeting, Kelly Building

Jan. 11-18 — MPhA Trip to Cancun — SIGN UP NOW —
SNOW IS COMING.

Feb. 14 — BMPA Dinner-Dance. SEE CHARLES
SPIGELMIRE FOR TABLES AND FOR MAN OF YEAR
TICKETS.

April 24-29 — APHA Convention, Las Vegas

Mar. 14 — Alumni Association Dinner Meeting

Jun. 20-24 — MPhA Centennial Convention Ocean City.

Dec. 8 — AZO Dinner Meeting — Chiapparellis, Towson.

Every Sunday Morning at 6:00 a.m. listen to Charles Spigelmir on WCAO broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore

Maryland Pharmacutists' Association

by
Ben Allen, Ph.D.



M. Joseph Muth (1837-1898) one of three brothers closely identified with the city's former oldest wholesale drug firm (Muth Brothers and Company) stated that as early as 1855 there was a decadence of the drug business in Baltimore due to jealousies and misunderstandings among the retail druggists. This led to a called meeting when a uniform price list was submitted and signed by all except three practitioners — Columbus V. Emich, J. Jacob Smith and Henry A. Elliot.¹

However, in a short time all were violating this attempt to maintain standard prices. For example, William S. Thompson (one of the first three graduates from the Maryland College of Pharmacy in 1842) complained that his neighbor (Laroque) was selling *Liquor Magnesii Citratis* at 25 cents instead of 40 cents as per list. At this time Thompson was located at 5 West Baltimore Street and the Laroque Store at 20 West Baltimore Street.²

The wholesale drug firm of Muth Brothers and Company was the direct successor of a similar business started by the Popplein Company on Liberty Street in 1837. In the early years of the firm many changes in ownership took place. In 1876 it was known as Thomsen and Muth and following the dissolution of this firm in 1884, John P. Muth, together with his brothers, M. Joseph Muth and George L. Muth formed a copartnership. In 1966 after 129 years of continued service this company concluded its career at 23-25 South Charles Street.³

Henry A. Elliott opened a drug store on the southeast corner of Lexington and Pine Streets in January 1853. He was very active in the affairs of the Maryland College of Pharmacy and served for many years on the finance and other committees of the college. In 1906, Mr. Elliott was elected President of the College.⁴ (Elliott's store was located near the new site of the University of Maryland School of Pharmacy, Baltimore and Pine Streets.)

The department stores in 1855 also contributed a share of injury to the retail drug business with "cut-rate" prices for several articles to be sold below normal to attract patrons. In 1862, William H. Read gave Baltimore its first "cut-rate" drug store. This store worried the druggists considerably,

causing some to advise meeting his prices, and the majority to endorse a regular campaign towards convincing the public — "that all accredited drugstore articles sold anywhere at irregular under rates were not genuine but spurious" — with the result that many persons thereafter patronized only the drug stores which maintained standard prices.⁵

In 1866, a twenty-seven page pamphlet entitled *Price List, Constitution and By-Laws of the Maryland Pharmacutists' Association* was published (printer: John W. Woods, 202 Baltimore Street, Baltimore).

The objects of the Association were to obtain reliable information as to the market prices of drugs and chemicals, to arrange a list of fair and uniform minimum retail prices for the use of its members, and for the promotion of the general interest of their craft.

The *Price List* included "raw" chemicals and drugs (vegetable, etc.), oils, preparations (vinegars, cerates, plasters, extracts, fluid extracts, liniments, solutions, pills), spirits, syrups, tinctures, ointments, wines, proprietary medicines (and toilet articles).

The 1866 pamphlet listed the name and address of eighty-seven members, many of them well known individuals associated with the Maryland College of Pharmacy. However, missing from this list were the names of C.V. Emich, J.J. Smith and H.A. Elliott. The following important statement appears in the above publication: "All persons who have signed the *List of Prices*, approved March 14th, 1865, shall be considered members of this Association without the formality of a vote."

It is interesting to note that in 1866 the following members of the Maryland Pharmacutists' Association were located on or near the present location of the Baltimore Campus of the University of Maryland: J. Brown Baxley, corner Howard and Franklin Streets, C. Bowers, corner Calhoun and Baltimore Streets; J. Wm. Bowers, 705 West Baltimore Street; E. Gover Cox, corner Baltimore and Pine Streets; J.L. Gibbons, corner Scott and Lombard Streets; J.H. Lemon, 659 West Baltimore Street; J.G. Nagle, corner Little Greene and Paca Streets; J.C. Ohlendorf, corner Howard

and Saratoga Streets; J.F. Perkins, corner Greene and Franklin Streets; E.H. Perkins, corner Greene and Baltimore Streets; John Stehl, 31 North Eutaw Street; J.V'D. Stewart, corner Hanover and Camden Streets; Wm. Seelbach, 445 West Baltimore Street; Woods and Russell, corner Baltimore and Eutaw Streets; Mrs. A. Wiseman, corner Baltimore and Fremont Streets; and Otto Wohlwend, corner Columbia (now Washington Boulevard) and Fremont Streets.

The minutes of the Maryland College of Pharmacy of January 9, 1868 records the dissolution of the Md. Phar. Asscn. as well as a note of thanks to Md. Phar. Asscn. (James P. Frames, secretary, corner Aisquith and Gay Streets).

At this College meeting, J. Brown Baxley (member of the Board of Trustees) read a communication from Md. Pharmaceutical Asscn. stating that the following preamble and resolutions were adopted at a meeting of M.P. Association. "Whereas the indisposition of the members of the M.P.A. to continue the organization for the purposes designated in its formation being made very apparent by their constant non-attendance at the meetings and their evident-

want of interest in it — therefore be it resolved that the Association be and is thereby dissolved. Resolved that the M.C. Pharmacy be requested to issue an advisory list of prices, the said list to be sold to Pharmacutists whether members or otherwise — resolved that surplus funds in the treasury, after an indebtedness is paid, be handed over to the M.C.P. for it's use". (M.C. Pharmacy and M.C.P. are abbreviations for Maryland College of Pharmacy).

On motion, a vote of thanks to the Md. Phar. Asscn. was tendered and it was resolved that the College get up an advisory price list without Proprietary Articles and the following committee were appointed. Messrs. Hancock, Kirby, C. Dohme, E.J. Russell, J.F. Moore, Jefferson, Eareckson and Frames.

It is interesting to note, that the Committee appointed by the Maryland College of Pharmacy on January 9, 1868 included the following individuals who were also listed as members of the Maryland Pharmacutists' Association in 1866: J.F. Hancock (Baltimore and Caroline Streets), T. Edward Kirby (Scott and Lombard Streets), E.J. Russell (Ann Street and Canton Aveune), J. Faris Moore (Howard and Madison Streets), J.B.H. Jefferson (86 South Broadway), and Jas. P. Frames (Aisquith and Gay Streets).

The Maryland College of Pharmacy was a membership institution organized in Baltimore in 1840 by apothecaries and physicians representing the Medical and Chirurgical Faculty. Of interest is the active participation of the College in the formation of the Maryland Pharmaceutical Association.

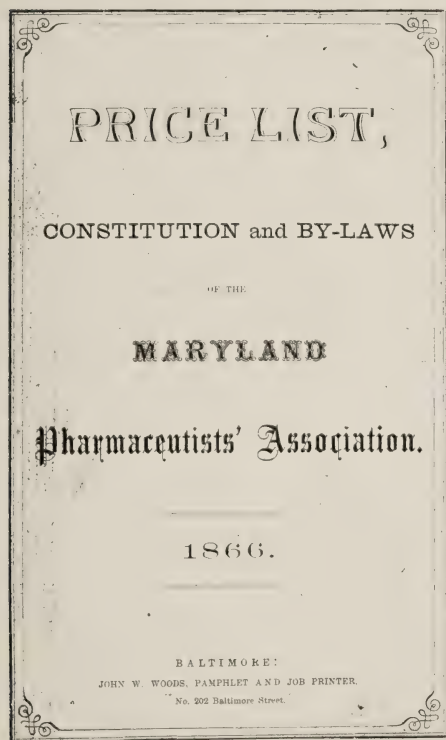
At a meeting of the Maryland College of Pharmacy, Board of Trustees on July 6, 1882, a statement was made that there was no organization in the State for the mutual protection of pharmacists, and wholesale and manufacturing drug-gists. Therefore, the use of the college building (east side of Aisquith Street, two doors north of Fayette Street, nine blocks directly east of City Hall) was offered as a place of meeting and twenty-five dollars was authorized to defray the expenses.

On October 5, 1882 the College president (Roberts) offered a series of Resolutions in regard to the formation of a State Pharmaceutical Association and a fifteen member committee appointed.⁶ Two members of this committee, J. Faris Moore and Edwin Eareckson were on the Maryland College of Pharmacy Advisory Price List Committee on January 9, 1868. Also, Mr. Moore was a member of the Maryland Pharmacutists' Association in 1866.

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1. David M.R. Culbreth, "Reminiscences of Early Pharmacy in Baltimore", J. Amer. Phar. Assoc., 19 (1930) 283-284.
2. David M.R. Culbreth, "Reminiscences of Early Pharmacy in Baltimore", J. Amer. Pharm. Assoc., 17 (1928) 1210-1216.
3. Joseph Muth, "History of Muth Brothers and Company", Maryland Pharmacists, December 1962, pp. 318-319.
4. Eugene F. Cordell, "University of Maryland", Volume — 1, the Lewis Publishing Company, New York-Chicago, 1907, p. 453.
5. Reference 1
6. Proceedings and Minutes of the Maryland College of Pharmacy, 1873-1899, pp. 208-209.

Author's Note: It appears that M. Joseph Muth's 1855 date should be 1865



The M.Ph.A. recently found this old "Price List" from the Maryland Pharmacutists' Association in the Kelly Memorial Building. This cooperative of pharmacists agreed upon the prices to be charged to the public and predates the M.Ph.A. which was founded in 1882.

We're listening, Baltimore

Managing a small independent chain means I'm dealing every day with all the problems that confront most small businessmen," says Wesley N. Shelton, R.Ph., who owns and operates four pharmacies in Baltimore, Md.

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Keep Pointed Toward Profit

by Jack H. Feller, Jr.
Managing Partner
J. H. Feller & Associates
Management Consultants
San Anselmo, California



Summary

Why do some business owner/managers hit the profit target more often than others? They do it because they keep their operation pointed in that direction. They never lose sight of the goal — to finish the year with a profit.

This article gives suggestions that should help an owner/manager to zero in on profit. It points out that you must keep informed, make timely decisions, and take effective action. In effect you must control the activities of your company rather than being controlled by them.

A beginner rarely shoots a hole in one, hits a bull's-eye, or hooks a prize-winning trout. Topnotch performance in golf, shooting, and fishing requires knowledge, practice, and perseverance.

Similarly, in small businesses, year-end profit comes to the owner/manager who strives for topnotch performance. You achieve it by knowing your operation, by practicing the art of making timely, balanced judgments and by controlling the company's activities.

Adapt the suggestions in this article to your situation. They should help you call the shots to keep your company headed in the right direction — toward profit.

Know Your Business

The time-honored truth "Knowledge is power" is especially pertinent to the owner/manager of a small business. To keep your company pointed toward profit you must keep yourself well informed about it. You must know how the company is doing before you can improve its operation. You must know its weak points before you can correct them. Some of the knowledge you need you pick up from day-to-day personal observation, but records should be your principal source of information about profits, costs, and sales.

Know Your Profit. The profit and loss statement (or income statement) prepared regularly each month or each quarter by your accountant is one of the most vital indicators of your business' worth and health. You should make sure that this statement contains all of the facts you need for evaluating your profit. This statement must pinpoint each revenue and cost area. For example, it should show the profit and loss for each of your products and product lines as well as the profit and loss for your entire operation.

It is a good idea to have your profit and loss statement prepared so that it shows each item for the current period, for the same period last year, and for the current year-to-date. For example, a P&L statement for the month of November would show income and expenses for the current month, for November last year, and totals for the eleven months of the current year. Many corporations publish their annual reports with several previous years so stockholders can compare earnings.

Comparison is the key to using your P&L statement. If your accountant is not already furnishing figures that you can compare, you should discuss the possibility of having them provided.

Financial ratios from your balance sheet also help you to know if your profit is what it should be. For example, the ratio of net worth (return on investment ratio) shows what the business earned on the equity capital invested.

Know Your Costs. An owner/manager should know costs in detail. Then, you can compare your cost figures as a percentage of sales (operating ratios). Be certain that your costs are itemized so that you can put your finger on those that seem to be rising or falling according to your experience and the cost figures of your industry. When costs are itemized, you can spot the culprit when the overall figure is higher than what you had budgeted. Take advertising costs for example. You can catch the offender if you break out your advertising expenditures by product lines and by media. In addition, a thorough check of inquiry returns from advertising will help to avoid unproductive publications.

In knowing your costs, keep in mind that the formula for profit is: Profit equals Sales minus Costs.

Know Your Product Markup. Be certain that the pricing of your products provides a markup adequate for the kind of profit you expect to achieve. You must keep constantly informed on pricing because you have to adjust for rising costs and at the same time keep prices competitive. Knowledge about your markup also helps you to run closeouts with your eyes open. Continuing to make a product that only a few customers want is an effective merchandising tool only when you use it on purpose — for example, to hold or attract buyers for other high markup products. Don't hesitate to drop a loser from your line.

Garbage-In, Garbage-Out. An owner/manager should not fudge the records. The acronym GIGO that the computer industry uses is true with manually kept records as well as with machine-processed ones. If an owner/manager allows "garbage" to go into the records, the reports will contain "garbage". Reports need not be extensive but they must be accurate.

Look For Trends. Try not to look at a single month's sales or profit picture by itself. The figures on your operating statements are meaningful only when you put the picture in the right frame — that is, look at your figures in the context of what has happened and what is likely to happen. In that manner, you catch a downward trend before it gets out of hand.

You should also concern yourself with the figures behind the dollars — for example, the number of units sold or the number of orders. Insist on cost-per-unit statistics. The fluctuation of these costs-per-unit can be much more meaningful than just looking at the dollar figures alone. Another idea is to display these comparative figures on graphs so that significant trends can be seen easily.

Predict Your Future

Don't use a crystal ball to make forecasts of your business. By carefully analyzing the historical trends of your business, as shown in your records for the past five years, you can forecast for the year ahead. Your records of sales, your experience with the markets in which you sell, and your general knowledge of the economy should enable you to forecast a sales figure for the next year.

When you have a sales forecast figure, make up a budget showing your costs as a percentage of that figure. In the next year, you can compare actual P&L figures to your budgeted figures. Thus, your budget is an important tool for determining the health of your business.

Make Timely Decisions

Without action, forecasts and decisions about the future are not worth the paper they are written on. A decision that does not result in action is a poor one. The pace of business demands timely as well as informed decision making. If the owner/manager is to stay ahead of competition, you must move to control your destiny.

Effective decision making in the small business requires several things. The owner/manager must have as much accurate information as possible. With these facts, you should determine the consequences of all feasible courses of action and the time requirements. When you have made the judgment, you have to set up your business so that the decision you make can be transmitted into action.

Control Your Business

To be effective, the owner/manager must be able to motivate key people to get the results planned for within the cost and time limits allowed. In working to achieve results, the small business owner/manager has an advantage over big business. You can be fast and flexible while many large firms must await committee action before a decision is made. You do not have to get permission to act. And equally important, bottlenecks to implementing new practices can receive your personal attention.

One of the secrets is in deciding what items to control. Even in a small company, the owner/manager should not try to be all things to everyone. You should keep close control on people, products, money, and any other resources that you consider significant to keeping your operation pointed toward profit.

Manage Your People. Most businesses find that their largest expense is labor. Yet because of the close contact with employees, some owner/managers of small businesses do not pay enough attention to direct and indirect labor costs. They tend to think of these costs in terms of individuals rather than relate them to profit in terms of dollars and cents.

Here are a few suggestions concerning personnel management:

1. Periodically review each position in your company. Take a quarterly look at the job. Is work being duplicated? Is it structured so that it encourages the employee to become involved? Can the tasks be given to another employee or employees and a position eliminated? Can a part-time person fill the job?

2. Play a little private mental game. Imagine that you must get rid of one employee. If you had to let one person go, who would it be? How would you realign the jobs to make out? You may find a real solution to the imaginary problem is possible to your financial benefit.

3. Use compensation as a tool rather than viewing it as a necessary evil. Reward quality work. Investigate the possibility of using raises and bonuses as incentives for higher productivity. For example, can you schedule bonuses as morale boosters during seasonal slacks or other dull periods?

4. Remember that there are new ways of controlling absenteeism through incentive compensation plans. For example, the owner/manager of one small company eliminated vacations and sick leave. Instead, this owner/manager gave each employee thirty days annual leave to use as the employee saw fit. At the end of the year, the employees were paid at regular rates for the leave they didn't use. To qualify for the year-end pay, the employee had to prove that sick leave was taken only for that purpose. Nonsick leave had to be applied for in advance. As a result, unscheduled absences and overtime pay were reduced significantly. In addition, employees were happier and more productive than they were under the old system.

Control Your Inventory. Don't tie up all your money in inventory. Use a perpetual inventory system as a cost control rather than a system just for tax purposes. Establish use

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**THESE TWO TEACH
YOU THINGS YOU
NEVER LEARNED
BEFORE - BUT WISH
YOU HAD.**



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patterns or purchase patterns on the materials or items you must stock to keep the minimum number required to supply your customers or to maintain production. Excessive inventory, whether it is finished products or raw materials, ties up funds that could be used to better advantage — for example, to open up a new sales territory or to buy new machinery.

Centralize your purchases and avoid duplications. Be a comparative shopper.

Confirm orders in writing. Get the price and amount straight right away.

Check what you receive for condition and quality. Check bills from suppliers against quotations. You do not want to be the victim of their errors.

You should, however, keep one fact in mind when you set up your inventory control system. Do not spend more on the control system than it will return in savings.

Control Your Products. From control of inventory to control of products is but a step. Make sure that your sales people recognize the importance of selling the products that are the most profitable. Align your service policies with your markup in mind. Arrange your goods so that low markup items require the least handling.

Control Your Money. It is good policy to handle cash and checks as though they were perishable commodities. They are. Money in your safe earns no return, and it can be stolen. Bank promptly.

Use credit wisely and take advantage of discounts. Pay bills early to get discounts if a discount is offered.

Keep a tight hand on your credit and collections. One of the hallmarks of a successful business owner/manager is knowing how much credit you can afford to extend over any period and how much you have already extended. Grant credit willingly, but keep it on a systematic basis. Insist on a written credit application and see that the credit application contains a promise to pay according to the credit practices in your industry.

Get your monthly bills out to customers on time, and be certain that bills show date of purchase, what was purchased, how much it cost, and how much was paid, if anything, and then how much is owed. The statement should also show your customer any overdue balance and for how long it has been overdue.

Every account will not pay promptly but keep in mind that a slow paying customer can be profitable, especially if the customers buys large amounts of your markup items. The danger is in letting such a customer get in beyond the ability to pay. Set up a system for collecting from late and slow paying accounts, but in reminding them to pay up, your objective is to get your money without losing their business.

Get Help When You Need It

It is good practice to use your outside advisors as you go along rather than calling on them only in emergencies. For example, your accountant can help you analyze the financial position of your business to help you avoid problems rather than to get you out of them.

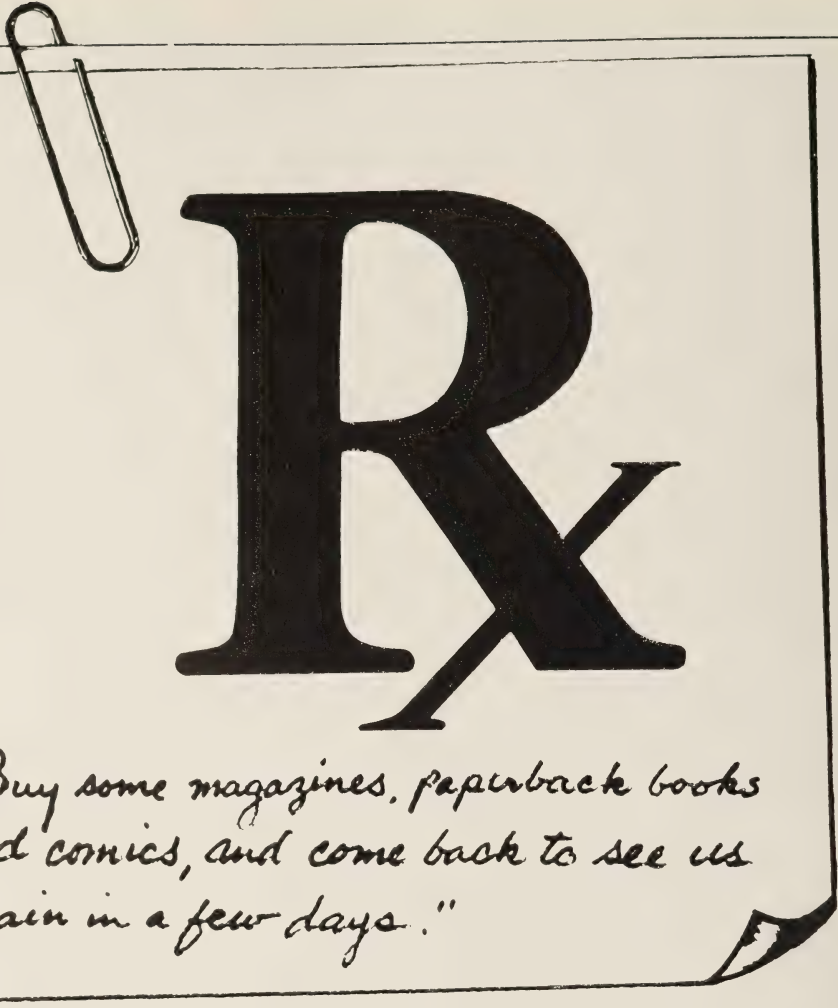
Sometimes an owner/manager needs to call in a management consultant. For example, help may be needed in isolating and solving a problem that the owner/manager senses but can't quite put a finger on. In other instances, the consul-

tant's professional background may be needed to supply skills that do not exist in the company — for example, the capability for doing market research or for setting up an inventory control system. In many cases, the management consultant can provide the time that the owner/manager lacks to implement a solution.



Licensing Board Telephone Numbers

Board of	Telephone
Exam. of Audiologists	383-6461
Dental Examiners	383-7534
Electrologists	383-7024
Medical Examiners	383-2020
Commission on Medical Discipline	383-7058
Examiners of Nurses	383-2084
Examiners of Nursing Home Administrators	383-2547
Examiners in Optometry	383-6461
Occupational Therapy Practice	383-7024
Pharmacy	383-7245
Physical Therapy Examiners	383-3248
Podiatry Examiners	383-6461
Exam. of Psychologists	383-7535
Exam. of Speech Pathologists	383-6461
Social Work Examiners	383-7247
Well Drillers	383-2709
Bd. of Chiropractic Exam.	589-2121
Bd. of Funeral Directors and Embalmers	269-3921
Bd. of Sanitarian Registration	777-5654



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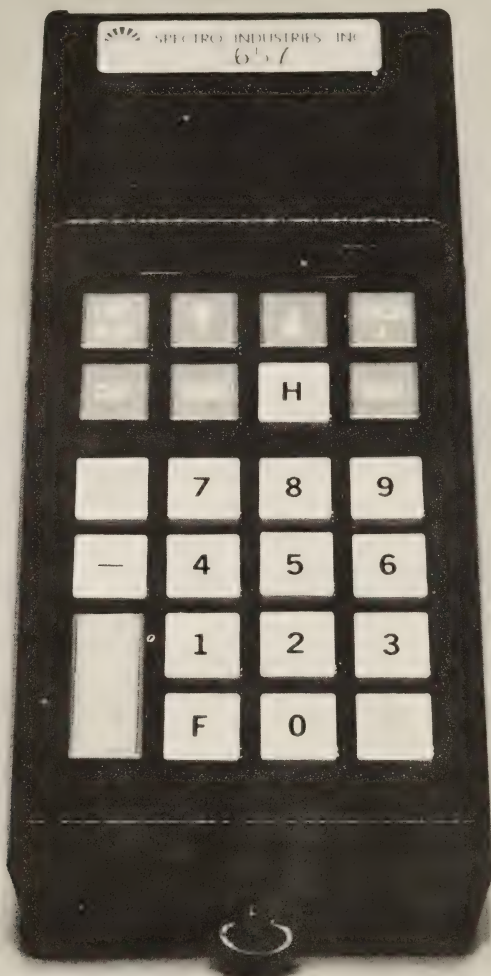
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Third Party Committee

Many pharmacies have seen their third party prescriptions climb to over half of their total volume, requiring a greatly increased paper-work load. Since almost all programs except Medicaid require the use of the Universal Claim Form which does not provide an identifiable space for the name of the drug, the use of National Drug Code (NDC) numbers is now routine.

The NDC number is broken into three portions. The first identifies the labeling company, and is assigned by FDA. The second and third sets are assigned by the company itself and identify the particular product, and the package size respectively. There often is an advantage to be able to tell the name of the company from the NDC number when reviewing claim forms. The accompanying list provides the NDC number for many of the companies. Often a company has been assigned more than one number to identify the division (Smith Kline French, SKF, etc.) or the place of manufacturer (Roche-USA, Roche-Puerto Rico).

National Drug Code

Manufactures Reference Numbers

ABBOTT-0074	FLEMING-0256	PURDUE FREDERICK-0034
ADRIA LABS-0013	FLINT-0048	PUREPAC PHARM-0228
ADRIA LABS-38242	FLINT LABS CAN-0951	REED & CARNICK-0021
AL-CON (PR)-0991	FOUGERA-0169	RACHELLE-0196
ALCON-0065	FULLER LABS-0141	REXALL-0122
ALLERGAN-0023	GEBAUER-0386	REYMAN-0771
ALLERGAN CAR-0109	GEIGY-0028	RICHYN-0115
ALLISON LABS-12154	GENERIX DRUG-0182	RINKER-0089
AMER QUINNE-0517	HOECHST PHARM-0039	ROBINS-0031
AMES CO-0193	HOLLAND-RANTOS-0027	ROCHE-0004
AMFRE-GRANT-0142	HOLLISTER STIER-0118	ROERIG-0049
ARMOUR PHARM-0053 -	HOYT LABS-0126	ROERIG/PFZER-0662
ARNAR STONE-0094	HUMCO-0395	RORER-0067
ARNELL LABS-19487	HWD-0011	ROSS LABS-0936
ASTRA-0186	ICN PHARM-0187	RUCKER-0524
AYERST-0046	INGRAM-0849	RUGBY-0536
AYERST INTL INC-50187	INWOOD LABS-0258	S K F-0007
BARNES-HIND-0077	IVES-0082	S M P-0058
BARRE-0472	J&J-0137	SANDOZ-0078
BARRY LABS-11463	KEY PHARCEUT-0369	SCHEIN-0364
BARRY MARTIN-0893	KNOLL-0044	SCHERER-11014
BAXTER LABS-0339	KREMER URBAN-0091	SCHERING-0085
BAY LABS-12280	LANNETT-0527	SCHMID-0234
BEECH-MAS LABS-0029	LEDERLE-0005	SEARLE-0014
BIALEKS-18329	LEDERLE METHOTR-0206	SEARLE LAB-0025
BIOCRAFT-0332	LEDERLE PARENTE-0205	SHERWOOD LAB-11034
BIOLINE-0719	LILLY-0002	SHERWOOD MED-8880
BOLAR-0725	M D V PHARM-49073	SK & F LAB CO-0108
BOOTS DRUG-11489	MALLINCKRODT-0019	SK&F CO-0484
BERON-0057	MARION LABS-0088	SPENCER-MEAD-0536
BRISTOL LABS-0015	MCNEIL-0045	SQUIBB-0083
BW-0081	MD PHARM-43567	STANLABS-36358
CANFIELD-0574	MEAD JOHNSON-0087	STANLABS PHARM-0242
CARNICK-0086	MERRELL-0068	STIEFEL-0145
CHELSEA-46193	MODERN DRUGS-33751	STUART ICI-0038
CIBA-0083	MOORE DRUG EXCH-0839	SYNTEX-0033
COOPER-0041	MORTON PHARM-12770	SYNTEX LABS PR-18393
COOPER DRUG-0779	MSD-0006	TEXAS PHARMACAL-0064
CORD-0117	MURO-0451	UNITED RESEARCH-0677
CUTTER LABS-0161	MYLAN-0378	UPJOHN-0009
DAN PHARM-0689	NAT PHARM MFG-0570	UPSHER SMITH-0245
DANBURY-0591	NORWICH-EATON-0149	VANGUARD-0615
DELBAY PHARM-0994	OBETROL-0477	USV-0075
DERMICK-0066	O'NEAL JONES & FELDMAN-0456	USV LABS PR-0070
DISTA-0777	ORGANON-0052	VANGUARD-0615
DOAK PHARMACAL-10337	ORTHO-0062	VICOBIN-0668
DOME LAB-0026	ORTHO PHARM PR-0107	VITARINE-0185
DOONER-0221	PANRAY-0318	WARNER-CHILCOTT LAB-0470
DORSEY-0043	PARMED-0349	WARNER-CHILCOTT PHARM-0740
DOW PHARM-0183	PARKE, DAVIS-0071	WALLACE PHARM-0037
DOYLES PHARM-12416	PENNWALT-0018	WAMPOLE LAB-0017
DRAKE PHARM-10348	PREIFER-0927	WARNER CHILCOTT LAB-0047
DRUMMER LABS-45124	PEIPHARMECS-0995	WESTWOOD-0072
ELDER-0163	PFIZER-0069	WILEN DRUG-11414
ENDO-0056	PFIZER PHARM-0663	WINTHROP-0024
ENDO INC-0060	PHARAMACIA-0016	WINTHROP PROD-0971
FEDERAL PHARM-0345	PHARMADYNE-49334	WOLINS PHARM-0928
FISONS-0585	PREMO-0331	WYETH-0008
FLEET-0132	PHILIPS ROXIANE INC-0010	ZENITH-0172
	PROCTER & GAMBLE-37000	

LETTERS



Dear Dave

Recently Lee Ahlstrom, P.D.,¹ offered Maryland pharmacists an after-the-fact justification of the M.Ph.A. action to adopt the "Pharmacy Doctor" designation for all pharmacists and regardless of academic achievement. The Association has already adopted the designation, and it appears that a late justification indicates a need to "sell" the idea to all of the membership. As one who is part of Maryland pharmacy yet primarily associated with a District of Columbia institution, I offer an educator's comment with intimacy but the distance (six miles) that may have me from the "heat" that might befall a U of M educator.

Why did author Ahlstrom put P.D. in quotation marks? You do that with something that does not fit into the normal flow of communications. This leads me to believe that the author and/or editor question the appropriateness of the title/non-degree/designation/whatever.

The optometry example of a process is totally irrelevant. For reasons good and bad, the vision care activities of optometry and optometric education have developed outside the traditional health care systems. The O.D. designation developed at a time when no college of optometry was affiliated with an academic health center such as those that exist at the University of Maryland and Howard University. Today only one optometric college and less than 10 percent of the students are enrolled in academic health center colleges. The optometry phenomena developed without the scrutiny and wisdom of the established health professions of medicine, dentistry, pharmacy, and nursing. If optometry had the luxury of being an integral part of health professions education, they would not have adopted a designation before a degree. My observation is not a defamation of optometry but an acknowledgement that the conditions related to pharmacy are extremely different.

The claim that the University of Maryland is shifting from B.S. to Pharm.D. programs needs to be documented with data. As one who is intensely interested in identifying Pharm.D. graduates for faculty practice, I am not aware of a large pool of Maryland graduates. Moreover, I am shocked by a claim of University programs for two-year pharmacy technicians. The only program offered by colleges of pharmacy for pharmacy technicians is a one-year, non-degree certificate offering by the Massachusetts College of Pharmacy and Allied Health Sciences.

Putting pharmacy's frustration and paranoia aside, the major cause of concern from the profession's academic community is credibility. We have worked long and hard for several generations to establish professional education pro-

grams worthy and well-recognized at the baccalaureate and doctoral levels and graduate programs at the master of science and doctor of philosophy levels. All of these programs developed within the context of high standards established by major universities. Given where we started, there is justifiable pride in our accomplishments. Call the P.D. a designation, but it will be interpreted by our fellow health professionals as a fraudulent academic credential. The fact that hospital pharmacists in the mother state of the P.D. designation, Indiana, have rejected the idea provides insight to the attitudes of those pharmacists who work most closely with other health professionals. If the Indiana experience is parallel to Maryland, we can expect not only a quick rejection at Hopkins and University, but also the creation of a trend that will eventually trickle to Govans and even to Oakland and Crisfield. Please save the profession from fraud, embarrassment, and all of the things we well know will come to someone who claims to be what he or she is not.

The most compelling argument for the P.D. is the paranoia and frustration that led to its creation. Having dealt with the B.S. and/or Pharm.D. debate for 10 years and the emotional debate between I.Ph.A., Director Clark, and Dean Kinnard, I recognize that we have found a professional issue that is tearing us apart. It may not be practically significant to the consumer but, to the practitioners and educators, it is a question of agonizing importance. Perhaps the profession and its mental health would best be served by accepting the fantasies of a doctoral profession without a degree and begin the implementation of first-degree Pharm.D. programs at all 72 colleges of pharmacy without serious regard for the scarce resources required to meet conventional standards for quality doctoral professional programs.

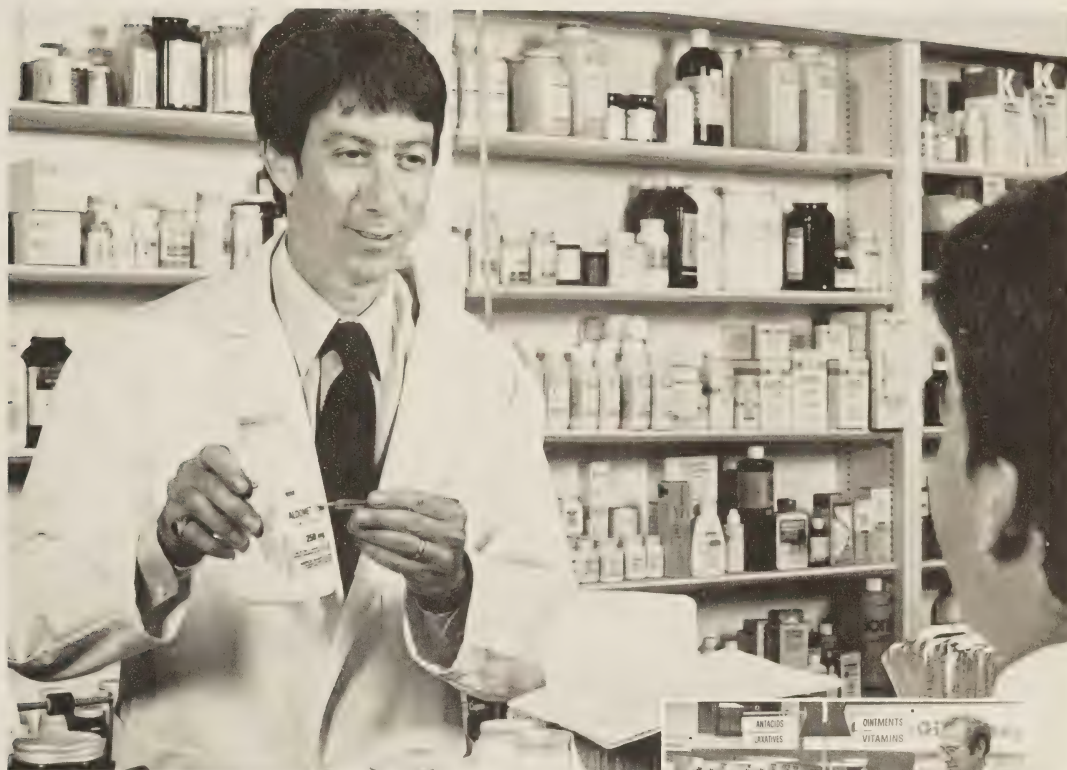
As one who has labored for more years than I care to count for high-quality in education and practice, it was difficult for me to write the previous paragraph. No doubt it reflects pharmacy's problem of being the health profession that we are not. A veteran federal bureaucrat once told me that all of pharmacy's problems were framed by pharmacists and the patient consumer was well-satisfied with pharmaceutical service. Perhaps by putting our internal unrest aside, we can better communicate to the public what their expectations from pharmacists should be and/or are we really ready for it with our current general level of professional competence?

Christopher A. Rodowskas, Jr., Ph.D.
Professor and Chairman
Department of Pharmacy Practice
Howard University

¹Ahlstrom, L. Why the P.D. Designation. *The Maryland Pharmacist*, 57, 9, 1981.

NOTE: For those with an interest in a more detailed exposition on this topic, the author would be pleased to provide a reprint of "A Matter of Degree," an article to be published in *Drug Intelligence and Clinical Pharmacy*.

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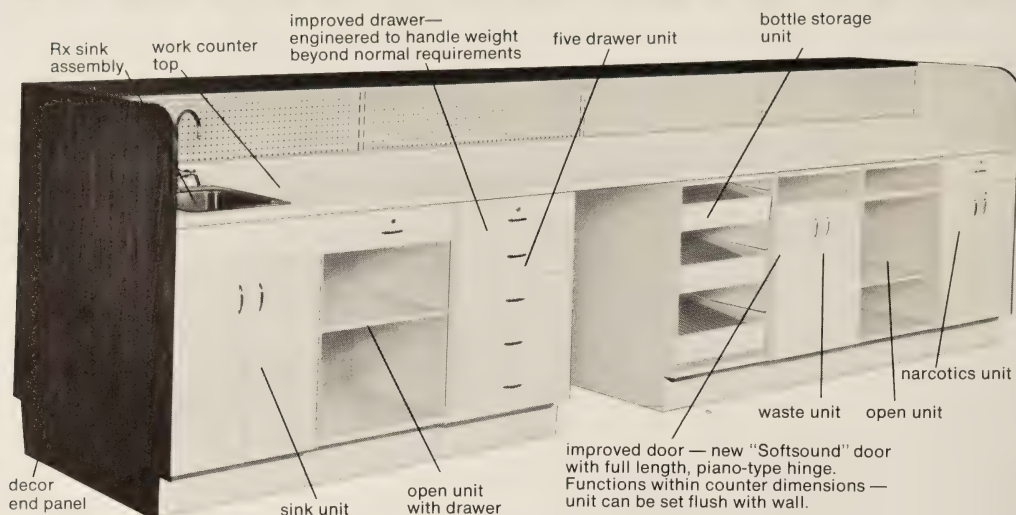


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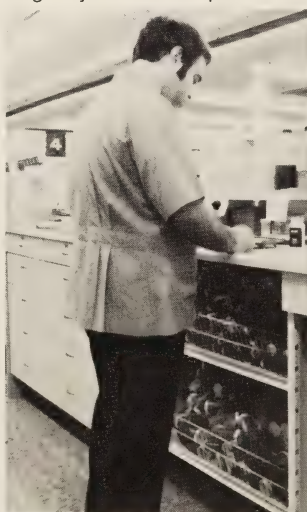
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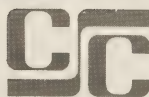
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Cindy Boyle (standing) was installed as President of the Upper Bay Pharmaceutical Association at the Installation Dinner held September 27, 1981. Also shown are: (left to right) Philip Cogan, President of the M.Ph.A.; Barbara Barron, Past President of UBPhA and Bob Turk, Baltimore Weatherman and guest speaker. Cindy's Speech appears on page 27 of this issue.

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“Making A Difference”

by

Cindy Boyle, President
Upper Bay Pharmaceutical Assn.

In considering a few remarks for the occasion tonight and in going through some back issues of journals (that I was sadly behind on) I was struck by the fact that in the profession of pharmacy, we are as much competitors as we are colleagues. Teachers compete in some ways for promotions or advantaged schools, but they are still colleagues in teaching and developing our children's skills. Civilian government workers compete for ratings, but they are still colleagues in their testing projects. TV commentators compete for top assignments and exposure, but are still colleagues in their efforts to find and report facts. Pharmacists, as those of us in the Upper Bay area know so well, compete for smaller and smaller pieces of the same business pie, as our population remains relatively constant and as one or two new pharmacies open each year in our area, but we are still colleagues in our commitment to contribute to the health of individuals and our community.

The differences and adversities we face as pharmacists at times seem multitudinous. One adversity that most people do not realize we face is that we have to hold meetings at ungodly hours to even get together. Only a very trusting husband would allow his wife to leave at 9:30 at night to go to the Flying Clipper in Aberdeen for a pharmacy meeting. We cannot even agree on what designation we should use, although the state association voted this summer that RPh was inappropriate and PD would be the title for pharmacists in Maryland. We differ on our approach to providing patient information to increasingly health-conscious customers (or should it be patients — we disagree on that, too.) We differ in opinion on the role of pharmacy associations in our professional lives and work environments. We disagree on the need for weapons in self-protection against armed drug-seekers. We differ on the method that our professional competence should be maintained-mandatory continuing education or not. I remember an earlier meeting this year when a PMA representative told us that just ten years ago, one-half of the top drugs that are prescribed today were not even on the market. That is a huge mass of information we have tried to absorb on our own, in many different ways.

Similarities and common concerns in pharmacy are also significant. On the lighter side, as pharmacists, we have all gotten that phone call that begins, “Hello. I am Mrs. Brewer, and I just talked to my doctor and he would like you to call *him* to get a prescription for my son, and they will leave the office in 10 minutes.” Only to call and be put on hold or to reach a recording. We can agree that third party carriers are squeezing our livelihood and complicate the practice of pharmacy when you cannot afford to dispense Danocrine or Duricef for a low fee. We can agree on the need to maintain competence in an everchanging field. We agree that we risk personal harm daily in our dealing with Controlled Danger-

ous Substances and want violent crime against pharmacies swiftly and strictly dealt with. We have common needs to improve our communication skills so that we can become effective patient educators/counsellors before Big Brother Government mandates what we must do and further closes in our professional prerogatives. We look toward improving our skills of business because it is only by nurturing healthy business that we can even afford to pay the invoices that keep the pharmaceuticals on the shelves for dispensing. So, in this area, the themes of loss prevention (internal and external), shrinkage control, public relations, outstanding debt collection, employee motivation and other administrative skills gain importance.

So what can an association, or particularly the Upper Bay Pharmaceutical Association, do to address our common concerns and promote our common goals as health professionals. Issues facing the organization are divisive because they affect pharmacists in different degrees. The comparison has been made that as pharmacists we cannot be like the person who refuses to attend church until all the members are perfect. As an association we can work politically. Political people hear the view of a very small percentage of the total population, but if pharmacists are among that percentage, we *can* make a difference — we *can* affect the outcome of PPI's, of mandatory price posting, and on and on. We can provide educational programs within the association through the combined efforts of drug companies, state associations, APhA, and schools of pharmacy for those many quality programs which will help ease the burden of keeping up. We can provide education to the community in Health Fair, March of Dimes Superwalk, Career Days, and Poison Prevention Week. Many of these things are services we have been providing all along but the public does not recognize our contributions. As an association we must improve our efforts to promote pharmacy and pharmacists. We can cross health profession lines. In some ways the medical association may be able to help us or visa versa in dealing with forged prescriptions, unauthorized office personnel okaying prescription refills, after-hours pharmacy services, etc.

As an association we accomplish something important if we do nothing more than meet together and exchange ideas, feelings and common experiences.

That fellow down the road isn't so bad afterall — he helped me out last week when I ran out of Cortisporin.

. . . Remember how several of us were almost taken by a “digital amputee” who was such a good actor and was making the round for Dilaudid.

. . . How so you work out your frustrations from the stresses of these long hours. I like a good game of tennis or a trip to the library with my daughter.

. . . In a world that revolves around weekends, we commiserate over working this one, but we also know the advantages of being off in daylight hours some times or in the middle of the week — I never shop on Saturday any more when most people have to . . .

Interaction is important and communication is constructive.

I am looking forward to working with you and for you this year. I salute you as colleagues and competitors and welcome your ideas.

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

URINARY TRACT INFECTIONS:

Some women seem to be especially susceptible to recurrent urinary tract infections. Investigators have obtained epithelial cell samples from the urinary tract of these women and have compared this tissue to that taken from controls. The samples taken from women who frequently have urinary tract infections tend to accumulate *E. coli* organisms, the bacterium most frequently associated with these infections. This might not only help explain why some women have more problems than others, but may also identify women who are likely to have such infections. *NENG J MED*, Vol. 304, #18, p. 1062, 1981.

RIBOFLAVIN:

The vitamin designated as vitamin B-2 (riboflavin) has to be activated before it can perform its vital functions. Studies conducted in animals indicate that the metabolic activation of this vitamin may be impaired by certain drugs including chlorpromazine (Thorazine), imipramine (Tofranil) and amitriptyline (Elavil). It has been suggested that signs of riboflavin deficiencies may be seen in patients taking these drugs on a long term basis. *J CLIN INV*, Vol. 67, #5, p. 1500, 1981.

VASECTOMY:

Researchers have studied the development of atherosclerosis in a large number of monkeys. Monkeys who had undergone vasectomy surgery seemed to develop this condition more rapidly than did those who were not exposed to the procedure. Although the full impact of this observation is not yet known, many clinicians feel that smoking, hypertension, and elevated serum cholesterol levels are more important risks of atherosclerosis. *JAM MED A*, Vol. 245, #20, p. 1991, 1981.

SUCRALFATE:

A new drug is being studied by Marion Laboratories in efforts to see if this agent might compete with cimetidine in treating ulcer patients. The drug, called sucralfate (Carafate) was found to be effective for short-term therapy in patients with ulcer disease. The drug is said to be devoid of serious side-effects probably because it is only minimally absorbed from the gastrointestinal tract. *FDC RPT*, Vol. 43 #19, p. 10, 1981.

ASPIRIN:

Patients undergoing surgery for removal of varicose veins were given either 80 mg. or 300 mg. of aspirin prior to the procedure. Studies showed that the larger dose of aspirin produced less favorable results on platelet aggregation than did the smaller dose. More studies are planned to determine the optimum dose of aspirin to take in order to prevent platelet aggregation. *LANCET*, Vol. 1, #8227, p. 969, 1981.

PROPRANOLOL:

Propranolol is used to treat symptoms of thyrotoxicosis. This condition exists when thyroid hormone is excreted in excess. It results in a general enhancement in body metabolism and it has been found that propranolol is metabolized more readily under these conditions. It may be necessary to use larger than normal doses of the beta-adrenergic blocker when treating patients with thyrotoxicosis. *ANN INT MED*, Vol. 94, #4, p. 472, 1981.

CANCER MARKER:

Investigators have found the presence of an unusual protein called S-100 protein in many patients with malignant melanoma. Some diagnosticians feel that this protein may be found in early stages of the disease and thus its presence may serve as a diagnostic tool in identifying patients in whom early treatment might be most beneficial. *LANCET*, Vol. 1, #8225, p. 869, 1981.

ANTITHROMBOTIC AGENTS:

Heparin has been used during hemodialysis procedures to prevent coagulation of blood as it comes in contact with the dialysis membrane. Heparin may be contraindicated in some patients and since its effects persist for several hours after dialysis, it could increase the likelihood of post-dialysis hemorrhage. Prostacyclin has been used successfully in place of heparin during dialysis and was found to not produce any side-effects and its activity was of shorter duration than that of heparin. *NENG J MED*, Vol. 304, #16, p. 934, 1981.

CYCLOPHOSPHAMIDE/FUROSEMIDE INTERACTION:

The use of high dose cyclophosphamide (Cytoxan) therapy may produce an antidiuretic effect and subsequent fluid retention. This side-effect can be managed successfully with the use of a continuous intravenous drip containing furosemide (Lasix). The only side-effect of this therapy was potassium depletion which was effectively countered with the use of potassium supplementation. *CLIN PHARM*, Vol. 29, #5, p. 634, 1981.

INTERFERON TOXICITY:

There has been a resurgence of interest in interferon utilization and thus studies of its toxicity were desirable. Most side-effects associated with administration of interferon are thought to be due to the antigenic components found in these crude preparations, and thus purified products were sought. Even these more purified preparations did not reduce some side effects. Symptoms such as tachycardia, increased body temperature, headache and malaise seem not to be dependent on the purity of the preparation used. The use of steroids or prostaglandin inhibitors to help reduce the severity of these symptoms has not been studied suffi-

ciently to ascertain if one can make the patient more comfortable yet not alter the effectiveness of the interferon. *BR MED J*, Vol. 282, #6273, p. 1345, 1981.

AZONE:

A new form of a transdermal vehicle has been undergoing experimentation in order to determine if it might help active drugs penetrate the skin more readily. The product, called Azone by the Upjohn Company, may be of value in enhancing activity of topically applied antibiotics such as those used to treat acne. *FDC RPT*, Vol. 43, #18, p. 15, 1981.

DDT:

The insecticide DDT was measured in people living in a town just below the location of a factory used to manufacture the material. Since the plant was located on a river, the amount of fish ingested/month was measured as well as the length of time the person had lived in the community. DDT and its metabolite, DDE, were found in highest concentrations in people who had lived in the community longest and in those who consumed larger quantities of fish. Fish taken from the river were found to have high concentrations of the insecticide in their tissues. No correlation could be made between levels of the toxin and specific disease states, although patients with high levels of DDT had elevated plasma lipid levels. *J AM MED A*, Vol. 245, #19, p. 1926, 1981

BENZODIAZEPINE ADMINISTRATION:

Intravenous administration of benzodiazepine derivatives has been associated with pain at the site of injection and efforts have been made to find ways in which this irritation may be reduced. It is suggested that toxicity may be reduced by injecting the drug in a large vein in the antecubital fossa, diluting the drug with the patients own blood before injecting, and by administering the drug slowly. Tissue damage can occur if the drug is injected into the skin or an artery. It is further suggested than when an intravenous injection of a benzodiazepine derivative is required, lorazepam be used because it is said to be less toxic than others in this pharmacological classification. *DRUG THER B*, Vol. 19, #3, p. 11, 1981.

OBESITY AND HYPERTENSION:

A study was conducted in 25 obese hypertensive patients for 12 weeks. The amount of sodium ingested was controlled and patients received either low or high amounts of sodium in their diet. All patients who lost weight experienced a reduction in blood pressure regardless of their sodium intake. Plasma renin activity and aldosterone levels were also reduced as weight was lost. *N ENG J MED*, Vol. 304, #16, p. 930, 1981.

PROCAINAMIDE METABOLISM:

The formation of N-acetylprocainamide (NAPA) from procainamide has been documented and the metabolite has found to have antiarrhythmic activity. Another metabolite of procainamide, desethyl procainamide, has recently been isolated from the urine of patients receiving the antiarrhyth-

mic drug. It was found to have less activity than either procainamide or NAPA and is not thought to be an important factor in the overall effectiveness of procainamide. *J PHARM EXP*, Vol. 216, #2, p. 357, 1981.

WARFARIN AND LUNG CANCER:

In a controlled, randomized study, the use of warfarin (Coumadin) seemed to enhance the survival time of patients with small cell carcinoma of the lung. It had been hypothesized that the blood coagulation mechanism is involved in growth and spread of cancer in man, and these observations tend to help support that hypothesis. More work is required before this observation will be considered as fact. *J AM MED A*, Vol. 245, #8, p. 831, 1981.

ACETAMINOPHEN TOXICITY:

Propylthiouracil, an antithyroid drug, was tested in-vitro and in-vivo to determine its ability to combine with the highly reactive metabolite of acetaminophen. The study shows that propylthiouracil will react directly with the metabolite in much the same way as does glutathione, thus reducing the toxicity associated with excessive acetaminophen ingestion. *J CLIN INV*, Vol. 67, #3, p. 688, 1981.

SPERM MOTILITY:

The human sperm obtains its motility by synthesizing acetylcholine as it is required. The effect is similar to that on smooth muscle, but the sperm does not have a storage facility for the transmitter, and thus it has to be made on demand. The tail portion of the sperm apparently synthesizes acetylcholine from choline and acetate under the influence of choline acetyltransferase. The acetylcholine stimulates the motility apparatus and then the transmitter is decomposed by acetylcholinesterase and thus could prevent the synthesis of acetylcholine. This could lead to a reduction in sperm motility and cause infertility in men. *J PHARM EXP*, Vol. 216, #3, p. 378, 1981.

PROPRANOLOL:

Patients with cirrhosis may experience intestinal bleeding due to rupture of esophageal or gastric varices or to acute gastric erosion. Twelve patients with histologically proven cirrhosis were given propranolol in doses which reduced heart rate by 25% while 125% while 12 others served as control subjects. Those receiving the propranolol had no gastric bleeding while 5 of the placebo-treated group experienced this problem. It is felt that propranolol reduced blood pressure sufficiently to make the rupture of the varices less likely to occur. *LANCET*, Vol. 1, #8226, p. 920, 1981.

IPRATROPIUM:

A new anticholinergic agent, ipratropium, has been used by the inhalation route to treat patients with acute asthmatic attacks. It compared well with results obtained when beta-adrenergic stimulants were used and further investigation indicated that an additive effect was achieved when the two drugs were used together. The combination of ipratropium and the beta adrenergic stimulant increased mean peak expiratory flow rates by 95% in four hours. *BR MED J*, Vol. 282, #6264, p. 598, 1981.

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December, 1981
VOL. 57
NO. 12



Update on Viruses and Antiviral Therapy

— Gary Magnus, B.S. Pharmacy

Medicaid Survival Numbers

Metro Crime Alert

**SEASON'S GREETINGS
from
the Board, Officers and Staff
Maryland Pharmaceutical Association**

THE MARYLAND PHARMACIST

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DECEMBER, 1981

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Any marketing technique that creates consumer pressure to influence prescribing practices will appall pharmacists and physicians alike. Boots Pharmaceuticals, Inc., who have the patent on ibuprofen, announced what they call "a 'first' in pharmaceutical marketing". They are generating lay press coverage of a \$1.50 rebate to consumers on each new or refill prescription for a 100 tablet bottle of their brand of ibuprofen, Rufen. That's a bottle of 100, not a prescription for 60, 90, etc. If the doctor writes for less than 100, no rebate. You can tactfully explain that to your irate patient.

According to the *F-D-C REPORTS* Boots said to pharmacists, "Because you will be saving your customers money, and providing them with an opportunity for a \$1.50 rebate, your customers will be thanking you—another benefit for you." Just think how many "thanks" you would get if every manufacturer promoted every product line this way. Would you have sufficient counter space for all the placards? I'm sure you would get a special thanks for each \$1.50 picked up by your patients whose prescriptions are covered by Medicaid or other third parties.

The potential impact of this kind of marketing can be disruptive. Your Association officers agreed at a recent Board of Trustees meeting that any attempt to create an artificial consumer demand for legend drugs should be censured. We know that the Board of Pharmacy has already been asked to inform the company that this gimmick is improper and perhaps illegal in the State of Maryland.

I don't know the extent to which the rebate is promoted in Maryland, but I hope each pharmacist informs the manufacturer that (s)he is insulted by the scheme, especially the kit they plan to distribute to certain pharmacists, wholesalers and physicians. I understand that the pharmacist kits contain brochures, questions and answers, patient pamphlets, color illustrations, tent cards and a sample bottle of 100 tablets, complete with a rebate coupon.

Philip H. Logan,

PRESIDENT

Update on Viruses and Antiviral Therapy

by Gary Magnus, B.S. Pharmacy*

Viruses, which may account for the smallest example of what we attempt to define as life, also account for the largest number of diseases recognized by man. The common cold and influenza viruses are the most common viral diseases known and are fortunately among the most mild of the hundreds of viruses known to attack man. Rabies on the other hand is over 99% fatal while Lassa fever and viral encephalitis also have a very high mortality rate. Effective vaccines have been available since Jenner used Cowpox vaccine to prevent Smallpox in the 18th century, however it has only been recently that antiviral chemotherapy and chemoprophylaxis have become a reality.

Several hundred viruses have now been associated with human and animal illnesses. However recently such diseases such as diabetes, multiple sclerosis, certain "collagen diseases" and some malignancies have also been theorized as being associated with viruses that may take months and even years to develop.

Physically viruses are all invisible by light microscopy as they range from 300 nm. down to 10 nm. in diameter. They are detectable now by electron microscopy and serological techniques, but earlier methods used micropore filters to isolate the organisms.

Transmission of viruses is mainly by direct contact with respiratory or enteric secretions with man serving as the primary host in most cases. However some viruses are animal or plant specific and are rarely (and only with the animal viruses) known to attack man; (Swine flu, horse encephalitis, Cowpox, and some others).

Their structure is relatively simple, consisting of: RNA or DNA (either single or double stranded), capsids, envelopes, and, recently discovered in some viral enzymes. (Figure 1.) Most viruses of clinical interest to man are double-stranded DNA, however the childhood diseases (Mumps, Measles, etc.) and flu/cold viruses are based on RNA. (Table 1.)

Capsids are a protein coat which directly surrounds the nucleic acid and is usually of either a helical or icosahedral formation. Capsids confer protection from cell nucleases and may play a role in attachment to host cells. Serological typing is usually based on capsid specificity.

The envelopes are not found in all viruses, but those that do possess one are found to be more susceptible to inactivation by inorganic solvents. The lipid and protein envelopes do play a critical role in viral attachment and penetration.

Viral enzymes are a new concept. It appears that some viruses, possibly a majority, may contain an enzyme or enzymes related to nucleic acid replication, specifically one that may catalyze synthesis of DNA in RNA viruses.

All animal viruses share several steps in the infection process. The first is attachment of the viral particle to a specific receptor on the host cell surface. This fusion results in the release of the viral nucleic acid into the interior of the host cell. After the capsid has dissolved, the replication of new viral nucleic acid and synthesis of new viral proteins begin. This is followed by assembly of the viral nucleic acid, capsids, and envelopes into mature virions. In many cases the virions are released with a general lysis of the host cell, in other instances the maturation of the virions is relatively slow and the release is done without the destruction of the host cell.

Diagnosis of viral infections is usually difficult due to the difficulty of culturing techniques and the time required for serological testing. In cases of the "common cold", influenza, smallpox and the childhood diseases, symptomology and transmission patterns are the best guides for identification of the disease. But many times definitive diagnosis may depend on retrospective serological studies in well equipped virology labs using agglutination, live cell culturing, or immunofluorescence techniques. These testing methods are usually done too late to affect treatment but may be useful in identification of similar cases especially if the disease is highly infectious.

Viral infections can lead to a wide range of cellular responses, these may be minor changes or may lead to cell lysis and death. Virulent strains may cause significant depression of cellular metabolism as they take over the cell's protein synthesizing systems in order to reproduce themselves. Other responses include; alterations in lysosomal stability, changes in surface membrane properties (which may allow the host immune system to destroy the infected cell), formation of giant multinucleated cells and the development of cellular inclusion bodies-which are stainable and along with the

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multinucleated cells aid in the detection of certain viruses (herpes, measles and rabies viruses).

Another process which occurs in the lab is agglutination which is very useful in the diagnosis and identification of many viral agents. The serological testing techniques are based upon this principle.

There are two particularly noteworthy properties of viral infections. The first is the oncogenic potential that some viruses possess. Some animal viruses are well-known carcinogens, but at this point no human virus has been positively linked to any form of cancer. However, the Epstein-Barr virus has been found in association with some lymphoid tissue malignancies, such as Burkitt's lymphoma. Breast cancer, Hodgkin's disease and uterine cancer have also been mentioned as having possible viral etiology.

Another notable property of some viruses is their prolonged incubation period. Kuru, a rare disease confined to natives of New Guinea, has been shown to incubate for up to eighteen months after transmission to other primates. Other degenerative diseases such as Creutzfeldt-Jakob disease, and possibly even diabetes may be viral linked with the organism taking years and possibly even decades to become virulent.

Of all the infectious diseases those of viral origin are the hardest to treat once the infection has taken hold, but in many cases they are among the easiest to prevent if a vaccine is available. Longterm prophylaxis against viral infections, also known as induction of active immunity, can be done by one of two methods; first is the use of inactivated or killed viruses and the second is the use of attenuated or live viruses.

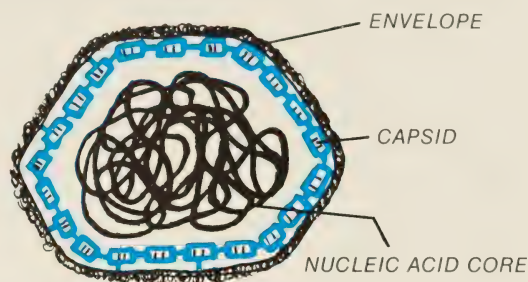


Figure 1. Structure of a complete virus particle.

TABLE 1. CLASSIFICATION OF VIRAL DISEASES OF HUMANS

Virus Group	Examples	Nucleic Acid	Symmetry	Diseases
Papovaviridae	Human Wart Virus	DNA	Icosahedral	Warts
Adenoviridae	Adenovirus	DNA	Icosahedral	Viral Pneumonia Eye Infections
Herpetoviridae	Herpes Simplex	DNA	Icosahedral	Type 1-Skin Lesions Encephalitis Type 2-Genital
	Varicella	DNA	Isosahedral	Chicken Pox Herpes Zoster-(shingles)
	Cytomegalovirus	DNA	Icosahedral	Mononucleosis Hepatitis Pneumonia
	Epstein-Barr	DNA	Icosahedral	Infectious Mono. Burkitt's Lymphoma?
Poxviridae	Variola major	DNA	Complex	Smallpox
	Vaccinia virus	DNA	Complex	Encephalitis
Picornaviridae	Poliovirus	RNA	Icosahedral	Polio
	Coxsackievirus	RNA	Icosahedral	Respiratory Inf.
	Rhinoviruses	RNA	Icosahedral	"Common Cold"
Togaviridae	Alphavirus	DNA	Icosahedral	Eastern, Western, & Venezuelan equine Encephalitis
Paramyxoviridae	Flavivirus	DNA	Icosahedral	Yellow Fever
	Paramyxovirus	RNA	Helical	Parainfluenza
	Morbillivirus	RNA	Helical	Measles
	Pneumovirus	RNA	"	Respiratory Inf.
Rhabdoviridae	Lyssavirus	RNA	Helical	Rabies
Arenaviridae	Arenavirus	RNA	Helical	Lassa Fever
Orthomyxoviridae	Orthomyxovirus	RNA	Helical	Influenza (A, B, & C.)
Unclassified	Hepatitis A & B		—	Viral Hepatitis

Inactivated or killed virus vaccines are more commonly used to prevent bacterial infections such as Diphtheria and Tetanus, however Influenza and the Salk-Polio vaccines are prepared by using formalin-inactivated cultures. Earlier preparations of Mumps, Rabies, Rubeola, and Rubella were made from inactivated viruses, but they have now been replaced by the use of live attenuated viruses.

Live attenuated viral vaccines use live cultures that are converted to nonvirulent strains by several different methods. These vaccines are available for smallpox, Polio (Sabin), Rubeola, Rubella, Mumps, Yellow Fever, Rabies, Adenoviruses (respiratory and eye infections), and Varicella (Chicken Pox). Many of these are given routinely in childhood (table 3), while others are reserved for either high-risk individuals or to prevent epidemics in areas of close contact such as military bases.

The other form of prophylaxis is to provide passive immunity with preformed antibodies. This method uses antibodies derived from either animal or human serum from individuals that have been exposed to the disease. Their use is limited to individuals that have been exposed to certain viruses and have no previous immunity to them. These gamma globulins are available for hepatitis, Vaccina, Varicella, Rabies, Mumps, Rubella, Rubeola and some bacterial diseases. The Center for Disease Control in Atlanta also has available if needed certain globulins and immune serums for such rare diseases as Lassa Fever, Simian Herpes, Western Equine Encephalitis and others. The human globulins are relatively safe, however use of animal sera may lead to hypersensitivity reactions. It is recommended that animal serums be used only when human serums are not available.

While the use of vaccines has been around since Jenner and Smallpox, (see Table 4) the use of chemotherapy or virucides is a fairly recent development. Amantadine has been available for influenza

prophylaxis only since 1966 and even now there are only four drugs on the market specifically for their antiviral properties. However there are over a dozen drugs that are being investigated for their antiviral actions with several possibly being marketed within the next few years. While vaccines cover over a dozen types of viral infections, the antiviral drugs now on the market cover only one type of influenza and several varieties of herpes infections.

The five drugs now approved for their antiviral use are:

AMANTADINE (adamantanamine HCl, Symmetrel®-Endo)

Mechanism: Amantadine appears to work by blocking penetration of the virus into the cell or inhibiting the uncoating of the virion after it has penetrated into the cell.^{12,17,18}

Use: Its major use is prophylaxis against Influenza Type A (dosage needed to prevent Type B is too toxic). It is best given before exposure although some suggest it may be effective up to 48 hours after exposure. Effectiveness after symptoms have appeared is being investigated with some studies indicating a reduction in temperature and a decrease in duration of the illness. The major recommendation for use is to prevent Influenza in high risk populations during epidemic situations, (nursing home populations etc.), however it is not recommended if Influenza vaccine has already been given; also the vaccine can be given concurrently and the Amantadine discontinued in a week to ten days.^{32,4}

Investigational Uses: Amantadine has been shown to inhibit Rubella, certain myxoviruses, and some tumor viruses.

Adverse Effects: The majority of side effects are central nervous system related and include confusion, dizziness, depression, slurred speech and blurred vision, orthostatic hypotension has also

TABLE 2. VIRAL INFECTIONS POTENTIALLY TREATABLE

Virus Group	Incidence	Mortality	Therapy/Prophylaxis
Influenza A, B, & C.	High	Low	Vaccine Amantadine (A only)
Mumps	Moderate	Low	Vaccine/Gamma Globulin
Adenovirus	Moderate	Low	Vaccine for military epidemics.
Polioviruses	Low	Moderate	Vaccine-Live oral Killed injection
Rubeola (Measles)	Low	Low	Vaccine/Gamma Globulin
Rubella (German Measles)	Low	Low	Vaccine/Gamma Globulin
Varicella-Zoster (Chicken Pox)	Moderate	Low	Vaccine/Gamma Globulin
Variola (Smallpox)	Extinct	Moderate	Vaccine (Cowpox)
Hepatitis A, & B.	Moderate	Low	Vaccine (1982) Gamma Globulin
Rabies	Low	High	Vaccine
Yellow Fever	Low	Moderate	Vaccine
Lassa Fever	Low	High	Immune Plasma
Equine Encephalitis	Low	High	Vaccine/Immune Globulin

TABLE 3. BASIC IMMUNIZATION SCHEDULE FOR INFANTS AND CHILDREN

Age	Product Administered
2-3 months	Diphtheria-Tetanus-Pertussis (DTP vaccine) Trivalent oral Polio vaccine (TOPV)
3-4 months	DTP.
5-6 months	DTP. TOPV.
12 months	Measles, Mumps, Rubella (all, live attenuated)
15 months	DTP. TOPV.
3-4 years	DTP, Measles, Mumps, Rubella, if not given earlier.
6 years or older	DT only-Adult strength.
1 year or older	Mumps vaccine (live, attenuated)

been noted. The elderly are particularly susceptible to these reactions which is unfortunate as its major use is in the geriatric population.

Pharmacokinetics: Amantadine is rapidly absorbed orally, has a half-life of around twenty hours, peaks in two to four hours and is 90% excreted unchanged in the urine. Excretion rate is increased significantly by an acid pH of the urine.

Administration: Symmetrel® is available both as 100 mg. capsule and a 50 mg/5ml. syrup. Recommended dosage is 200 mg. once a day or in divided doses. An initial dosage of 100 mg. QD. may be appropriate in the elderly until the side effects can be properly monitored.

Labeling Advice: May cause dizziness or blurring of vision, caution if driving or operating heavy equipment. Avoid alcoholic beverages.

VIDARABINE (adenine arabinoside, Vira-A®, -Parke Davis)

Mechanism: Vidarabine, a purine nucleoside, is believed to involve the inhibition of viral induced DNA-dependent DNA polymerase after it is metabolized to Ara-hypoxanthine.^{4,6,16,18,12}

Uses: First available as an ophthalmic ointment for use against herpes simplex keratitis, it is now also available for I.V. administration in the treatment of herpes simplex encephalitis.^{15,20}

Investigational Uses: Vidarabine has also been found to be effective in vitro against herpes zoster, acute cytomegalovirus encephalitis and cytomegalovirus retinitis, pseudorabies, rabies, myxoma and monkeypox.³⁰ One study involving neonatal herpes simplex infection showed poor results.²⁹ Vidarabine has shown antineoplastic properties and is being tested in hematological malignancies.

Adverse Effects: When used ophthalmically, blurring, burning, irritation, pain, photophobia, tearing and increased sensitivity have been reported. Nausea, other G.I. symptoms, anorexia, weakness, tremor, ataxia, dizziness, and other CNS symptoms have been reported when used I.V. Hematologic toxicity has been reported in immunosuppressed patients. It has also been shown to be mutagenic in vitro and is contraindicated in pregnant women.

Pharmacokinetics: When given IV its half life is 1½ hrs. for the parent compound and 3.3 hrs. for the

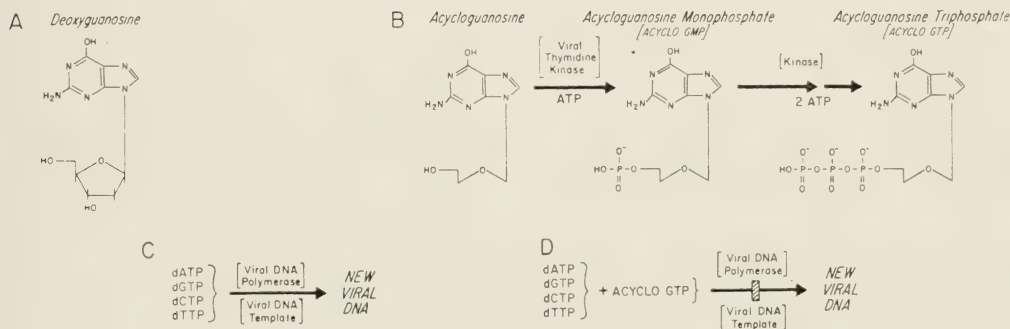


Figure 1. Mode of Antiviral Action of Acyclovir (Acycloguanosine) against Susceptible Herpes Group Viruses.

A shows the structure of deoxyguanosine. B shows the structure of acycloguanosine (an analogue of deoxyguanosine) and steps in its conversion to acycloguanosine monophosphate (acyclo GMP) (by the herpes-specific viral thymidine kinase) and to acyclo GTP. C shows the synthesis of viral DNA by a herpes-specific viral DNA polymerase from the four deoxynucleoside triphosphates: adenosine, guanosine, cytosine, and thymidine. D shows the block in viral DNA synthesis produced by acyclo GTP at the DNA polymerase step.

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xanthine metabolite. There is only a small amount of absorption when used ophthalmically.

Administration: Vira-A® comes as a 3% ophthalmic ointment to be used every three hours up to five times a day for a minimum of one week. For IV use a 200 mg/kg/day suspension is available to be given at 10-15 mg/kg/day by slow infusion (12-24 hours) up to 10 days of therapy. The manufacturer states that each mg. of Vidarabine should be dissolved in a minimum of 2.2 ml. of solution.

Labeling Advice: Be sure to complete entire course of therapy but no longer without your physician's knowledge.

IDOXURIDINE (5-iodo-2'-deoxyuridine, Stoxil® -Hoescht)

Mechanism: Idoxuridine is incorporated in place of thymidine into viral DNA resulting in a faulty gene and the inability to reproduce or infect tissue.^{3,12,18,32,33,34}

Uses: Its primary indication is also in the treatment of herpes simplex keratitis and keratoconjunctivitis.

Investigational Uses: Idoxuridine has also been found to be effective against varicella-zoster, vaccinia, cytomegalovirus, and other DNA viruses. It has shown no activity against RNA viruses and in a blinded study using intravenous infusions showed no difference in mortality or morbidity in treatment against herpes simplex encephalitis.

Adverse Effects: Idoxuridine's side effects are similar to Vidarabine however the frequency of pain and eyelid irritation is greater and its use today is limited. It is also mutagenic and should not be given to pregnant women.

Pharmacokinetics: It is poorly absorbed from the eye. When used IV experimentally it is metabolized in the liver and excreted renally.

Administration: Stoxil® comes as both a 0.1% solution and a 0.5% ointment. Dosing is every two hours around the clock, except the ointment can be used every four hours at night. It should be used for at least seven days and preferably at least a week after healing to prevent reoccurrence.

Labeling Advice: Store in a cool place. May be refrigerated. Continue medicine for full course of therapy. Do not use more often or longer than ordered.

TRIFLURIDINE (trifluorothymidine, Viroptic® Burroughs Wellcome)

Mechanism: Trifluridine is incorporated into viral DNA in place of thymidine as with Idoxuridine.^{12,14,18}

Uses: It is indicated primarily in the treatment of keratoconjunctivitis and recurrent epithelial keratitis caused by herpes simplex virus, types I and II.

Investigational Uses: Trifluridine has been shown to inhibit Adeno- and Vaccinia viruses in vitro. It is

also under investigation for systemic treatment of neoplastic disease.

Adverse Effects: Trifluridine's side effects are burning, stinging, itching, redness and rare hypersensitivity reactions which occur much less frequently than either Stoxil® (Idoxuridine) or Vira-A® (Vidarabine). For this reason Viroptic® is now considered the drug of choice in ophthalmic herpes. As with the other two it is mutagenic and should not be used in pregnancy.

Pharmacokinetics: Systemic absorption is minimal despite its greater water solubility than Vidarabine or Idoxuridine. Its half life in the eye is 12 to 18 minutes.

Administration: The 1% solution should be used every two hours when awake but may be reduced to every four hours after healing has occurred. The recommended dosage is one drop.

Labeling Advice: Refrigerate. Continue medicine for full course of treatment. Do not use longer or shorter than ordered.

CYTARABINE (cytosine arabinoside, Ara-C®, Upjohn)

This drug's mechanism of action is probably to inhibit the synthesis of deoxycytidine or deoxycytidylic acid. It is active in vitro against herpes and pox viruses however since it is 10× as toxic as Trifluridine & Vidarabine, it is no longer recommended for use as an antiviral agent.⁴ In fact one recent study showed that Cytarabine was of no benefit in disseminated herpes zoster and in severely immunocompromised patients may increase the risk of morbidity and mortality.¹⁹ Another study even suggested that immunosuppressed patients may actually have an increased risk for development of disseminated herpesvirus infection owing to further depression of host defenses by the drug.

All the drugs listed above are effective antiviral agents but cover only a few viral infections, principally ophthalmic herpes. There are now many investigational drugs being tested for other viral diseases especially herpes genitalis, which is becoming more of an epidemiological problem than ever. Most of these investigational drugs act directly against the viruses, however there are two drugs that are immunopotentiators which stimulate the body's own defenses to combat the infection. Of these drugs being tested many show great promise, but others are showing variable results.

Acyclovir (acycloguanosine) is now appearing to be one of the most promising drugs that is effective against many types of viruses.^{4,10,11,27,28,31} This drug was developed after it was discovered that viral-specific thymidine kinase differed from normal host cell kinase. This compound, which is similar to structure to deoxyguanosine, is converted to Acycloguanosine triphosphate by viral thymidine kinase and is a competitive inhibitor of the deoxyguanosine triphosphate for the viral

DNA polymerase. The Acyclo-GTP produces a synthetic block which results in termination of the viral DNA chain. (See figure 2). Acyclovir was found to inhibit viral thymidine kinase (10-30 \times more effectively than host cell polymerase. In vitro studies have shown Acyclovir to be 160 times more active against herpes simplex Type 1 than Vidarabine is and 10 times more active than Idoxuridine. It has also been shown to be effective against herpes simplex Type 2, herpes simiae, varicella-zoster, Epstein-Barr virus and cytomegalovirus. However, it has not been shown to be effective against vaccinia, adenovirus, some RNA viruses and mutant viruses that lack thymidine kinase. Human studies have shown excellent results against both topical and systemic herpes zoster and simplex, as well as herpes genitalis, keratitis, and encephalitis. After intravenous infusion Acyclovir has shown a half-life of 2.2 to 5 hrs., is around 22 to 33% protein bound and is excreted 95% in the urine with about $\frac{2}{3}$ of that in the unchanged form. The drug is remarkably nontoxic with the only adverse reaction noted so far being an increased BUN in a few patients. IV. administration dosage is 2.5-10 mg/kg/day usually given every 8 to 12 hrs for 5 days. Topical use is usually done with a 3-5% ointment used five times daily. An oral dosage form is also being investigated and recently an ophthalmic formulation for use in herpes simplex keratitis has been marketed in England.

Ribavirin is a synthetic nucleotide that has shown some activity against a variety of DNA and RNA viruses including herpes simplex types 1 and 2, vaccinia, influenza types A and B, and parainfluenza.^{21,32} However in vivo studies have shown little or no effect on herpes skin lesions, vaccinia keratitis and encephalitis, cytomegalovirus and hepatitis B. Some effect has been noted in parenteral use against herpes encephalitis, Lassa fever and Influenza types A and B. The drug interferes with the biosynthesis of viral DNA by inhibiting an enzyme, inosine monophosphate dehydrogenase, and may also partially inhibit RNA synthesis. Following oral administration of either 1 gram/day for 5 days or 800 mg./day for 10 days plasma level were found to peak within 1-1.5 hrs with a half-life of about one day. Doses are generally well tolerated, although gastrointestinal symptoms have been experienced. Teratogenic studies have been inconclusive, but it is not recommended for use in pregnant women.

A recent report in JAMA showed successful treatment of herpes genitalis with 2-Deoxy-D-glucose (2DDG).⁷ In this study of 36 females, 89% were cured with the 2DDG with the lesions healing twice as fast as compared to placebo (8 vs. 18 days), with the symptoms clearing in 12 to 72 hours of therapy. Its mechanism appears to be inhibition of glycosylation of the viral envelope proteins. As 13% of all venereal diseases are now herpes infections this compound may prove most beneficial, but this report has been criticized and larger studies are needed to confirm this finding. Administration of 2DDG was done in a buffered acid jelly.

Bromovinyldeoxyuridine (BVDU) like Acyclovir is selectively toxic to viral replication and is activated only within an infected cell. It has been found effective against herpes simplex type 1 skin lesions and keratitis in mice. One recent study in immunosuppressed patients undergoing chemotherapy found that oral administration of 7.5 mg/kg/day in three or four divided doses caused prompt recovery from severe localized or disseminated herpes zoster.²⁶ Existing lesions regressed within the first few days of therapy and no new lesions developed while on the drug. There was no evidence of toxicities or side effects.

Two studies described the use of (+)-cyanidanol-3 in acute viral hepatitis.²⁵ Using two grams daily it was noted in the double-blind study that there was a significant decrease in disappearance of hepatitis B surface antigen from the blood with those patients using the active drug. There was also noted a relief from anorexia, nausea and pruritus and a lowering of serum bilirubin levels normally associated with the illness.

Interferon, which has been getting much coverage as a possible anticancer agent, was discovered originally to be an antiviral agent produced by the body when an invading virus is present.⁴ Basically interferon induces the production of cellular enzymes that subsequently block viral reproduction by inhibition of the translation of viral messenger RNA into viral protein. Experimentally it has been shown that interferon may be induced by viruses, nucleic acids, endotoxins, large polysaccharides, bacteria, synthetic polyanions and other substances. Clinical studies have shown interferon effective in preventing dissemination of herpes zoster in cancer patients, suppressing viremia with hepatitis B in chronic active hepatitis and some reduction in visceral symptoms in both varicella and zoster infections. It has shown excellent results in combating rhino- and influenza viruses, but results have been variable in herpes keratitis and genitalis, and cytomegalovirus.²⁴ Other studies have shown some benefit in combining interferon with other antivirals such as Trifluridine and Vidarabine, but much work needs to be done with the very scarce and costly compound.²³ Basically interferon seems to work better at preventing infections than in treating active ones. Adverse effects include fever, bone marrow depression, nausea and vomiting, temporary hair loss and an inhibition of growth in young children. Eventually recombinant DNA-produced interferon, which is now in phase I trials, will produce larger and cheaper quantities of the drug and more research into its anti-viral and antineoplastic uses can be established.

Immunopotentiating agents do not work against viruses themselves but stimulate the body's own defense systems to combat the viral infections. Levamisole was originally discovered as an antihelminthic agent, but recently it was found that the drug has an immunomodulating action, particularly on cellular immune responses. While studies have shown the drug to be ineffective in preventing viral infections, it has shown

"Tween Scripts"

By Jake Miller, Pharmacist
Manager, Professional Relations
A. H. Robins Company, Inc.



Honoring Pharmacy's "Extra Effort" People

Again this fall, current year recipients of the A. H. Robins "Bowl of Hygeia" Award, selected by their peers through their professional pharmacy associations in the 50 states, the District of Columbia, Puerto Rico, and the 10 Canadian provinces were invited to be guests of our company for a special salute in our Richmond headquarters.

The three-day event included receptions and dinners, tours of our manufacturing and research facilities and a sightseeing trip to Williamsburg, the restored colonial capital of Virginia.

It was a desire to encourage pharmacists to take more active roles in community affairs that prompted E. Claiborne Robins, chairman of the board of A. H. Robins Company and a pharmacist himself, to establish the "Bowl of Hygeia" Award in 1958. The award provides special recognition to the men and women of pharmacy for their many and varied community services.

Some have served in their state legislatures and on city councils. Others have filled important positions on planning and zoning commissions and hospital, school and other boards. They have provided leadership for fund drives and countless special projects, and have participated in the work of youth organizations, civic clubs, churches and fraternal organizations. Perhaps a

quarter of the nearly 1,400 recipients thus far have headed their state or provincial pharmaceutical associations at one time or another.

The award is a handsome plaque featuring the Bowl of Hygeia cast in bronze. So that they may be

recognized wherever they go, award winners are also presented lapel pins which are scale replicas of the plaque, and at any gathering of pharmacists, those wearing the pin form a proud "alumni" of previous recipients.

A. H. Robins is pleased to be able to assist state and provincial associations in recognizing these "extra effort pharmacists."



Jake Miller

A. H. ROBINS

A. H. Robins Company
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effectiveness in reducing symptoms and duration of upper respiratory tract infections in children, acute viral hepatitis in adults and showed a significantly better reduction in frequency, duration and severity of herpes genitalis attacks than placebo, especially after eight weeks of administration.^{22,32} Dosage is 2.5 mg/kg. of body weight given orally 2 days per week for 26 weeks. Adverse effects include nausea, vomiting, diarrhea, nervousness, metallic taste, and febrile illness. Most of these effects are transient and disappear without need to change therapy.

Inosiplex (isoprinosine, methisprinol) was originally described as an antiviral agent, but more recently studies have focused on its immunopotentiating properties.^{8,9,21,32} While Levamisole tends to stimulate lymphocytes and macrophages directly, Inosiplex enhances the stimulating effects of other agents such as antigens. Its antiviral activity in animals has shown mixed results. One study showed a high rate of recovery against viral encephalitis as did another study on its use against herpes simplex, but other studies against influenza and rhinovirus have shown increased humoral responses but no lessening of symptoms. It is rapidly metabolized when given orally or IV with half lives of 50 min. (oral) and 3 min. (IV). Toxicity is low with the adverse reactions being transient nausea upon oral administration and slight transient increases in serum and urinary uric acid. Recommended usage abroad, where it is approved, is against viral encephalitis, it is not recommended prophylactically as it does not appear to be effective and may even interfere with normal host response. The recommended dosage is 100 mg/kg/day at weekly intervals for 3 to 9 courses of therapy.

Another substance now being investigated is a synthetic polypeptide, (polyribinosinic acid/polyribocytidylic acid or poly I:C). This compound is also not an antiviral agent but has received much attention as an inducer of interferon. However low titers of induced interferon probably limit its usefulness as an antiviral agent. One study of topical poly I:C showed no effectiveness against viral respiratory infections and in the treatment of localized herpes zoster in children with cancer. A similar compound poly(ICLC), made by complexing poly (I). poly (C) with poly-L-lysine and carboxymethylcellulose, was shown to be effective in preventing viremia and death in rhesus monkeys exposed to simian hemorrhagic fever.³²

Other drugs that have been tried as antivirals but are no longer used as such include:—Dactinomycin which is used as an antineoplastic agent but was found to be too toxic as an antiviral, Puromycin—which inhibits synthesis of the protein coat, but was not found to be viral specific, Rifampin—now in use for TB, inhibits DNA dependent-RNA synthesis in both viruses and bacteria and was reported to have been used topically with human vaccina viruses with mixed results and finally Methisazone—which was very effective against smallpox and may yet prove effective against other poxviruses.³⁴

In the near future Acyclovir will probably be mar-

keted for herpes genatalis and other herpes infections, a new hepatitis B vaccine will become available in 1982 and other drugs will most likely be discovered and tested for use as antiviral agents. But for now the best and most effective treatment is still prevention with the use of vaccines that are now available. If a person is exposed to certain viral infections such as rabies and a vaccine can be given as it will induce immunity before the disease can become virulent. In other cases such as hepatitis or Lassa fever an immune globulin can be given to provide passive immunity. Of the antiviral agents on the market only Amantadine has been proven effective when used prophylactically, although many of the investigational drugs may also prove useful as preventive agents.

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LETTERS



Dear Sirs:

At the recent convention of the Alpha Zeta Omega Pharmaceutical Fraternity the following resolution was passed:

Be it resolved that the Alpha Zeta Omega Pharmaceutical Fraternity would like to congratulate the Maryland Pharmaceutical Association on the celebration of their centennial anniversary. Best wishes for continued success.

Sincerely yours,
Alan Abrams
Supreme Signare
For Supreme Directorum
Irving Barron
University Heights, Ohio

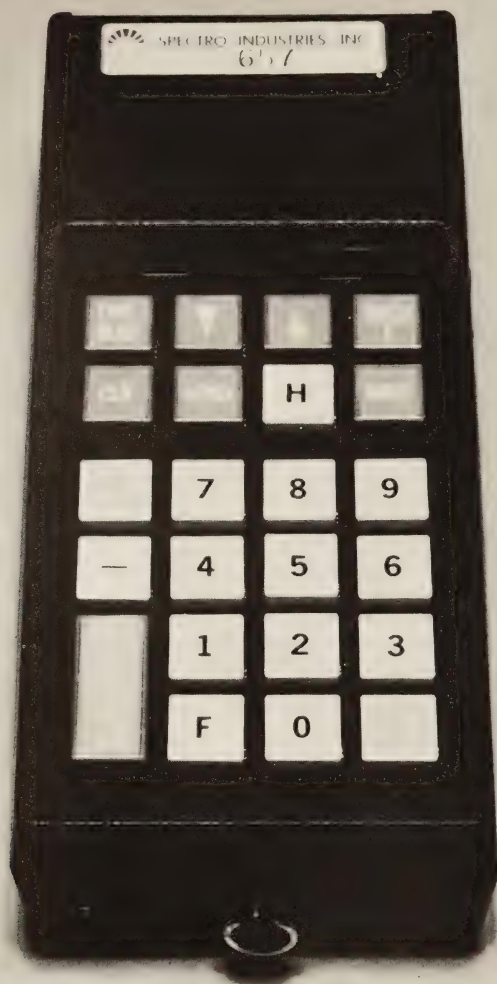
Dispensing Patient Education



Expanding Pharmacists Role

129th Annual Meeting
American Pharmaceutical Association
April 24-29, 1982
Las Vegas, Nevada

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Perspectives in Pharmacy

Patient Drug Information

Presented
in the interest of
better-informed
pharmacy

Neil L. Pruitt, R.Ph., President
National Association of
Retail Druggists

"The delivery of health care in our communities is changing. Traditional institutions are giving way to home health care and outpatient clinics. Handicapped persons with their special needs for durable medical equipment and health supports and appliances require personal attention. The increase in over-the-counter products that were once



Neil L. Pruitt, R.Ph.

prescription-only means that more customers will require counseling on their use. An increasing drug-dependent elderly population will rely more than ever on the professional advice of their pharmacists.

"Patient counseling will become more important than ever before because of the hosts of different populations we are seeing in our stores—the handicapped, the elderly, the teenager who has more money to spend on cosmetics, the consumer who

wants to know about the efficacy of the drugs he or she is taking.

"Talking to our customers gives us a unique marketing advantage because we know who they are and what they want. Service is, indeed, one of our keys for survival."

Dorothy L. Smith, Pharm.D.
Director of Clinical Affairs
American Pharmaceutical Association

"The pharmacist has an excellent opportunity to test the patient's recall of the information provided by the physician, to make the prescription instructions readily understandable, and to reinforce the patient's faith in the prescribed therapy.

"The type and amount of information required will vary with the specific needs of the patient. But generally, patients want enough information to help them complete the therapy *as easily and as safely* as possible.

"Almost all patients will have questions about applying the drug regimen to their own schedules. They are willing to modify their daily activities to accommodate a dosage schedule if they understand why the changes are best for them. But these questions can be answered only on an individual basis.

"Handing the patient a full disclosure sheet does not effectively help 'educate.' In fact, a long list of potential adverse effects may even convince a patient *not* to take the medication.

"Every effort must be made not to frighten the patient. Basically, the role of the pharmacist is to help a patient use drugs most effectively and with the least anxiety."

Reprinted from American Pharmacy, Vol. NS 21, No. 7, p. 382

John F. Schlegel, Pharm.D., M.S.
Executive Director
American Association of Colleges of Pharmacy

"Most pharmacy professionals recognize the importance of communication skills. Indeed, depending on one's particular perspective, personal pharmacy service that emphasizes patient education can be a source of immense satisfaction, enhanced professional image, increased patronage, and improved health care through better understanding and use of medicines.

"Influences both inside and outside the profession point toward a resurgence of personal

contact between the pharmacist and the patient. The public's 'right to know' cannot responsibly be denied. The problem has been in finding time in the pharmacy student's busy curriculum for proper communication skills training.

"For the past several years, colleges of pharmacy have been increasing the quantity and quality of training in this area, and greater attention is being paid to the influence of personality types on professional motivation.

"In the future, the 1980's will likely be described as the 'Communications Era' in pharmacy. The profession has made significant advances, but there is still a need for more change."



Dorothy L. Smith, Pharm.D.



John F. Schlegel, Pharm.D., M.S.



Eli Lilly and Company
Indianapolis, Indiana 46285

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ANNUAL REVALIDATION...

of each representative's product and technical knowledge is Roche policy. And it's a good policy, as it ensures that our people keep abreast of developments in this dynamic field.

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will reflect this extensive training each representative receives. Questions that involve more detailed information get prompt attention from Roche Professional Services.



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- ☐ Liberal Return Goods Policy
- ☐ Roche Medical Emergency Line for Pharmacists and Physicians
- ☐ Drug Abuse Warm Line
- ☐ RETRIEVE—Roche Computerized Information System
- ☐ RESPONSE—Product Information and Consultation
- ☐ Pharmacist Antibiotic Therapy Test (PATT)
- ☐ Depressive Disorders Therapy Test
- ☐ Roche Pharmacy Seminar Series for Continuing Education



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LIST OF MAC DRUGS

PRODUCT	MAC LIMIT	EFFECTIVE DATE
Acetaminophen w/codeine, 30 mg tablets	\$.0780 per tablet	1-25-79
Acetaminophen w/codeine, 60 mg tablets	.1545 per tablet	1-25-79
Amoxicillin, 250 mg capsules	.2106 per capsule	6-28-79
Amoxicillin, 500 mg capsules	.3942 per capsule	6-28-79
Ampicillin, 250 mg capsules	.0595 per capsule	1-25-79
Ampicillin, 500 mg capsules	.1103 per capsule	1-25-79
Ampicillin oral suspension, 125 mg/5 ml	.0145 per ml	10-25-77
Ampicillin oral suspension, 250 mg/5 ml	.0205 per ml	10-25-77
Chlordiazepoxide HCl, 5 mg capsules	.0149 per capsule	10-15-79
Chlordiazepoxide HCl, 10 mg capsules	.0211 per capsule	10-15-79
Chlordiazepoxide HCl, 25 mg capsules	.0438 per capsule	10-15-79
Dicloxacillin Sodium, oral capsule, 250 mg	.2690 per capsule	12-8-80
Diphenoxylate HCl/atropine sulfate, mg 0.025 mg tablets	.0491 per tablet	10-15-79
Doxepin HCl, 100 mg capsules	.2900 per capsule	10-15-79
Doxepin HCl, 10 mg capsules	.0950 per capsule	1-25-79
Doxepin HCl, 25 mg capsules	.1161 per capsule	1-25-79
Doxepin HCl, 50 mg capsules	.1765 per capsule	1-25-79
Erythromycin Stearate, 250 mg tablets	.0697 per tablet	1-25-79
Erythromycin Stearate, 500 mg tablets	.1250 per tablet	1-25-79
*Glutethimide, oral tablet, 500 mg	.0432 per tablet	8-28-81
Hydralazine HCl, 25 mg tablet	.0279 per tablet	3-31-80
Hydralazine HCl, 50 mg tablet	.0384 per tablet	3-31-80
Hydrochlorothiazide, oral tablet, 25 mg	.0152 per tablet	12-8-80
Hydrochlorothiazide, oral tablet, 50 mg	.0194 per tablet	12-8-80
Meprobamate, 200 mg tablets	.0108 per tablet	1-25-79
Meprobamate, 400 mg tablets	.0117 per tablet	1-25-79
Methocarbamol, 500 mg tablets	.0496 per tablet	10-15-79
Methocarbamol, 750 mg tablets	.0640 per tablet	10-15-79
Penicillin G, 400 mu tablets	.0237 per tablet	10-15-79
Penicillin G, 800 mu tablets	.0640 per tablet	10-15-79
Penicillin VK, 250 mg tablets	.0535 per tablet	10-25-77
Penicillin VK, 500 mg tablet	.1025 per tablet	10-25-77
Penicillin VK oral suspension, 125 mg/ml	.0120 per ml	10-25-77
Penicillin VK oral suspension, 250 mg/5 ml	.0160 per ml	10-25-77
Potassium Chloride, oral liquid, 10%	.0030 per ml	12-8-80
Probenecid, 0.5 gm tablets	.0644 per tablet	1-25-79
*Procainamide HCl, oral capsule, 250 mg	.0383 per capsule	8-28-81
*Procainamide HCl, oral capsule, 375 mg	.0505 per capsule	8-28-81
*Procainamide HCl, oral capsule, 500 mg	.0585 per capsule	8-28-81
*Propantheline Bromide, oral tablet, 15 mg	.0235 per tablet	8-28-81
Propoxyphene HCl, 65 mg capsules	.0317 per capsule	4-24-81
Propoxyphene HCl, with APC, 65 mg capsules	.0330 per capsule	4-24-78
Quinidine Sulfate, oral tablet, 200 mg	.0688 per tablet	12-8-80
Sulfisoxazole 500 mg tablets	.0273 per tablet	10-15-79
Tetracycline HCl, 125 mg/5 ml syrup	.0104 per ml	10-15-79
Tetracycline HCl, 250 mg capsules	.0250 per capsule	4-10-78
Tetracycline HCl, 500 mg capsules	.0465 per capsule	4-10-78

* Additional MAC Limit effective August 28, 1981

Medicaid Survival Numbers

Listed are Medical Assistance Program telephone numbers which are important to providers.
Questions concerning:

1. Policy and Procedures383-2658
2. Prescription Invoice Reimbursement383-6893
3. Reimbursement of Invoices for Disposable383-2954
Medical Supplies and Durable Medical Equipment
4. Medicaid Recipient Eligibility383-6480
and Claims Verification
5. Medicaid Forms383-2067
6. Preauthorization
Preauthorization for prescriptions with an usual and
customary charge exceeding \$40.00 and preauthorization
for covered disposable medical supplies with a usual
and customary charge exceeding \$40.00 call383-7716 or 7717

Providers calling for preauthorization from outside
the Baltimore Metropolitan calling area call—
toll free1-800-492-6006

DO NOT USE THE PREAUTHORIZATION TELEPHONE NUMBERS
FOR ANY OTHER PURPOSE OTHER THAN OBTAINING
PREAUTHORIZATION. These lines must be kept open
for their intended use.

7. Imprinter Information—Operations Administration383-6898
8. Provider Payment Information—
Operations Administration383-6481
9. Provider Number Information—
Operations Administration383-6898
—New Providers
—Change of Add, name, etc.
10. Program Abuse—Reporting—
Compliance Administration383-7377, 6376

Pharmacy Assistance Program

Information Concerning Pharmacy Assistance Program363-2567

Division of Drug Control

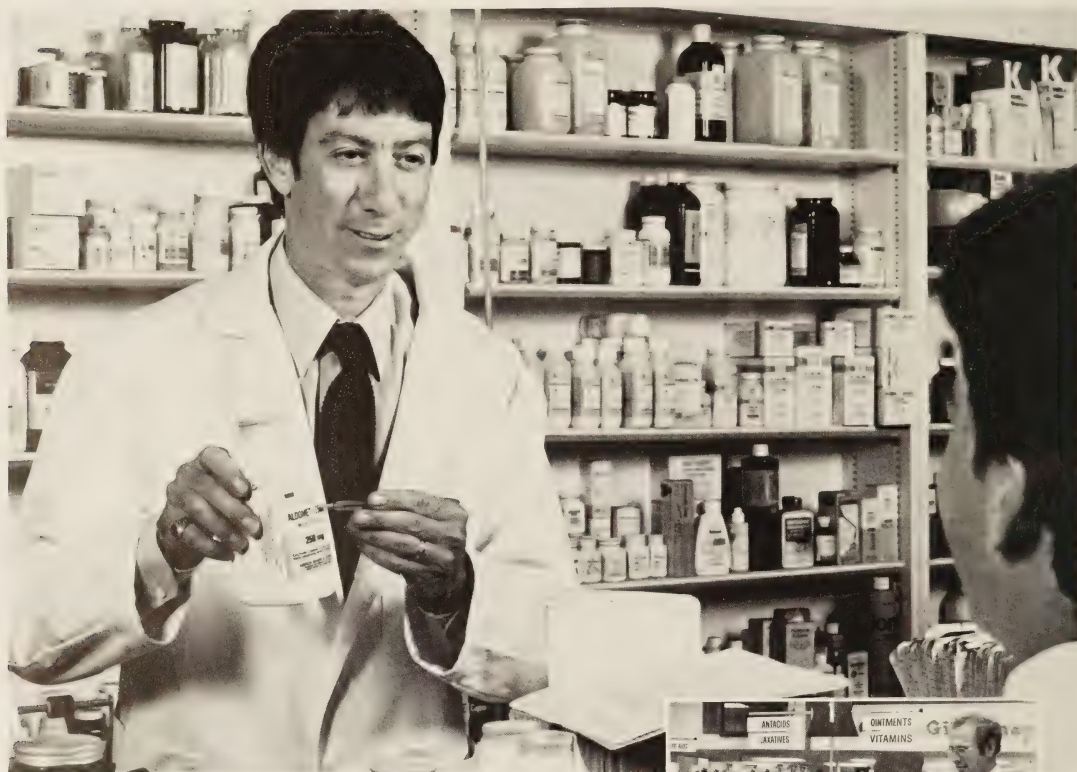
Information Concerning Maryland Pharmacy Law383-2729

OTHER IMPORTANT NUMBERS

Maryland Pharmaceutical Association727-0746
FDA NDA/ANDA verification301-443-1016
Division of Labor and Industry
Employment of minors659-4314
1-800-494-7521
Lie Detector Law659-4177
1-800-494-7521
Medicare Claims and Benefits825-8711
Blue Shield Claims and Benefits825-7200
Blue Cross, Major Medical and Dental
subscriber services828-4630
Maryland Board of Pharmacy383-7245
Drug Enforcement Administration962-4800
Small Business Administration962-4392
U of M. School of Pharmacy528-7650
Howard School of Pharmacy1-202-636-6530
Maryland Sales Tax Division383-3800
Maryland Income Tax Division383-3100
Internal Revenue Department962-2590

Your Important Numbers

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We realize that you, as an independent businessman, need a wholesaler who understands your *total* needs. Not just product, but advertising, inventory control, and management assistance. We're staffed with experts who can help your business grow. Rely on us.

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 Paul Hawbecker

Wilmington Division
 (302) 655-7401
 Ed McKenna

Baltimore Division
 (301) 866-4600
 Al Turner

Johnstown Division
 (814) 288-5702
 Neil Smith

Drug Stability Testing Program

Because of the responses received from hospital pharmacists regarding the pilot stability study conducted on Digoxin Tablets last year, the American Society of Hospital Pharmacists, the United States Pharmacopeia and the Food and Drug Administration are continuing the program to learn more about the shelf-life stability of drugs under actual market conditions. Selected groups of drug products will be tested to gain an indication of their stability in the face of real life conditions such as time, variable temperatures and humidities of storage facilities, and container protection in handling and shipment.

The Drug Stability Testing Program is not directed towards any one manufacturer or labeler; rather, it is an attempt to gain an overall assessment of the real-life stability characteristics of drug products. The products that have been selected for study at this time are:

1. Digitoxin Tablets
2. Nitroglycerin Tablets (Sublingual); and Nitroglycerin Ointment
3. Dexamethasone Sodium Phosphate Injection; and Dexamethasone Acetate Injection

Under the procedures of the program, hospital pharmacists have been requested to notify USP if they have any unopened bottles in their possession within one year of their expiration date.

Upon receipt of the notification USP will either

1. Mail the pharmacist a postage-paid mailer to send the sample in and a reimbursement check for the drug; or
2. notify the pharmacist that sufficient samples from that particular geographic area have already been received and that particular sample will not be needed.

Upon receipt of the sample, the USP will forward it to the FDA for analysis. USP will also notify the manufacturer that a sample of its product has been received by the FDA and that it can obtain a portion should it so desire.

Each response received by the USP will be assigned a code number and personal identification such as names and addresses will not be sent to the FDA or the manufacturer or other parties. USP will act as a go-between should any further information be needed.

Once a sample is analyzed by FDA, the results will be given to USP who will then send the analytical results to the manufacturer of the product and to the participating pharmacist.

The Project Director for the Program will be Joseph G. Valentino, Executive Associate of the United States Pharmacopeial Convention.

Pharmacists Are Ethical

In a Gallup poll of public perceptions of various professions and occupations, pharmacists were rated second in response to the question: "How would you rate the honesty and ethical standards of people in these different fields?"

Only clergymen rated higher than pharmacists. Insurance salesmen, advertising practitioners, and car salesmen scored the lowest marks in the poll.

Clergymen received high or very high marks from 63 percent of the 1,564 persons interviewed nationwide. Pharmacists were close behind with 59 percent describing their integrity as high or very high.

Completing the top half of the 24 occupations and professions which were ranked were dentists, physicians, engineers, college teachers, policemen, bankers, television reporters and commentators, newspaper reporters, funeral directors, and lawyers, in descending order.

Making up the lower half were stockbrokers, U.S. senators, business executives, building contractors, U.S. representatives, local political officeholders, real estate agents, labor union leaders, state political officeholders, insurance salesmen, advertising practitioners, and car salesmen.

The poll, taken July 24 to 27, had a margin for error of plus or minus three percentage points.

From the APhA Newsletter
Public perceptions of honesty and ethical standards

	Very high, high %	Average %	Low, very low %	No opinion %
Clergymen	63	28	6	3
Pharmacists	59	33	5	3
Dentists	52	38	7	3
Physicians	50	38	10	2
Engineers	48	35	5	12
College teachers	45	36	8	11
Policemen	44	41	13	2
Bankers	39	47	10	4
TV reporters, commentators	36	45	15	4
Newspaper reporters	30	49	16	5
Funeral directors	30	41	19	10
Lawyers	25	41	27	7
Stockbrokers	21	46	7	26
U.S. senators	20	50	25	5
Business executives	19	53	19	9
Building contractors	19	48	27	6
U.S. representatives	15	47	32	6
Local political officeholders	14	51	30	5
Real estate agents	14	48	30	8
Labor union leaders	14	29	48	9
State political officeholders	12	50	30	8
Insurance salesmen	11	49	36	4
Advertising practitioners	9	41	38	12
Car salesmen	6	33	55	6



A Brief History of the Maryland Board of Pharmacy

Early pharmacists were responsible for compounding drugs and assuring drug quality. They were, in fact, frequently referred to as chemists. The nature of the profession has changed—today, most prescription drugs are manufactured in finished form by pharmaceutical manufacturers. Quality is assured by the U.S. Food and Drug Administration.

The modern pharmacist is responsible for correctly selecting and dispensing prescription drugs, advising consumers on both prescription and over-the-counter drug use, maintaining proper records as required under Federal law, and assuring the safe and secure storage of drugs. The vast majority of Maryland's 4,000 pharmacists practice in local retail pharmacies which could not operate without professional expertise. Most of the remainder are employed in hospital or institutional pharmacies.

Regulation of pharmacy in Maryland began in 1872 with a provision in the Public Local Laws of Baltimore City intended "to prevent incompetent persons from conducting business as a pharmacist or vending, at retail, drugs, medicines, or chemicals for medicinal use in the City of Baltimore". The local law was repealed 30 years later when the State undertook the regulation of pharmacy. Chapter 179 of the Acts of 1902 defined a pharmacy and authorized the Governor to appoint a five-member Board of Pharmacy Examiners to register pharmacists and assistant pharmacists. This law, the Maryland Pharmacy Act, has been amended 64 times since 1902. Significant changes manufacturers, producers, and distributors of drugs and to inspect places where drugs are manufactured, packaged or sold in the State. In the same year, medicine shows and other unsafe methods of drug distribution were prohibited. The Board stopped issuing licenses to assistant pharmacists. In 1961, the General Assembly added provisions for the suspension, revocation, and renewal of licenses for pharmacists and assistant pharmacists. The grounds for disciplinary action have since been expanded. Chapter 643 of the Acts of 1967 allowed the Board to adopt rules and regulations to govern the practice of pharmacy. The Board was enlarged in 1976 and again in 1980. The Maryland Board of Pharmacy is currently composed of eight members appointed by the Governor to staggered five-year terms. Six of the members must be licensed,

practicing pharmacists; two must be consumers. Two members must be residents of Baltimore City and two must be residents of other counties in the State.

The Drug Enforcement Administration (DEA) of the U.S. Department of Justice also licenses all persons and firms involved in the manufacture, distribution, and dispensing of drugs. The DEA license for pharmacies is based on the State licensing process. A pharmacy which holds a valid certified pharmacy license, and has not been involved in a drug-related crime, normally receives a DEA license automatically.

The Board regulates approximately 4,000 pharmacists, 175 student pharmacists yearly, 800 pharmacies, 50 drug manufacturers, and drug 100 drug distributors as well as the practice of pharmacy by:

1. Conducting examinations and issuing licenses;
2. Reviewing and investigating complaints, and when necessary, holding hearings to revoke or suspend a license; and
3. Establishing and amending rules and regulations necessary to enforce the Pharmacy Practice Act.

Applicants for a pharmacist license in Maryland must be graduates of a school or college of pharmacy accredited by the American College of Pharmaceutical Education or approved by the Board. Applicants must additionally have 1,560 hours of experience. The University of Maryland's School of Pharmacy has a "Profession Experience Program" and all graduates meet this requirement.

Candidates for a license to practice pharmacy must additionally pass a standardized licensure exam which is owned and developed by the National Association of Boards of Pharmacy (NABP), a Maryland jurisprudence exam developed by the Maryland Board of Pharmacy Examiners and a practical examination, also developed and administered by the Board.

All students enrolled in a school of pharmacy in this State must annually register with the Board.

The Board also issues pharmacy permits to those who comply with all aspects of the pharmacy law requiring proper equipment, supervision, and sanitation.

Manufacturing and distribution permits are issued to all who meet Federal Drug Enforcement Administration qualifications.

Metro Crime Alert

What is Metro Crime Alert?

Metro Crime Alert is an organization of local citizens and business people created to increase public involvement in the fight against crime in Baltimore City, Baltimore, Anne Arundel and Howard Counties

How Does It Work?

The initial effort is a cash reward program for information in response to a crime highlighted by the mass media each week. Any citizen may call the 24-hour, 7 day hotline—276-8888 to give this information. \$1,000.00 will be paid and anonymity will be given to citizens who furnish information leading to the arrest and indictment of felony-crime offenders. Other rewards of \$50.00 to \$1,000.00 will be made for information which leads to arrest and indictment of any other unsolved felony. In all cases complete anonymity is guaranteed to all callers. You do not have to give your name.

Q: Why does this program include Baltimore City, Anne Arundel, Baltimore and Howard Counties?

A: Crime does not respect city/counties boundaries. For Metro Crime Alert to be most effective, a regional approach is vital. In this manner the greater Baltimore area will be knit with a metropolitan crime prevention network.

Q: For which types of crime will Metro Crime Alert pay rewards?

A: Rewards will be given for information that results in an arrest and indictment for any of the following felony crimes: Homicide, Rape, Aggravated Battery, Armed Robbery, Auto Theft, Auto Burglary, Residential Burglary, Commercial Burglary, Larceny, Forgery, Fraud, Embezzlement, Arson, Narcotics, Vice and Fugitives.

Q: What will happen if false information is given? Will this result in false arrests?

A: False information may occasionally be passed on, but an arrest would never be made solely based on phoned-in information. The police will launch a thorough investigation to check out each caller's claims. The emphasis of Metro Crime Alert will be to make the public more aware of its civic responsibilities in reporting criminal activity.

Q: Will the caller who gives information be required to testify in court?



A: Each caller is guaranteed complete anonymity. The caller will be assigned a secret number to guard his or her identity. A case-law precedent was established in New Mexico that such programs are not required to divulge the identity of callers for court testimony. Even the reward is paid in cash as a safeguard. But if a caller does wish to testify, he or she may, of course, do so.

In Sum

Metro-Crime Alert is a program whose success rests on the response of metropolitan area residents. Since crime cuts across all lines in victimizing citizens, it is essential that all citizens play an active role in helping Metro Crime Alert by offering any information they may have concerning unsolved felonies. As Metro Crime Alert succeeds, every citizen will have an added degree of protection and our area will become a safer place in which to live and work.

If you have any questions about Metro Crime Alert, please contact Dr. Simon Fuchs, at (301) 337-9770, or write P.O. Box 5393, Baltimore, Maryland 21209.


Business or other groups or individuals who would like to support the on-going efforts of this organization may make tax-deductible contributions to:

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The FDA's NDA, ANDA paper-NDA: What does it all mean?

NDA: New Drug Application. This application submitted to the Food and Drug Administration (FDA) is necessary to obtain permission to market a new drug for human use in interstate commerce. Preparation of an NDA is a very costly and time-consuming process.

ANDA: Abbreviated New Drug Application. This application submitted to the FDA is all that is required to obtain permission to market a drug that is identical or closely related to a drug product that has previously satisfied the NDA requirements *and was approved for marketing prior to October 10, 1962*. An ANDA need not contain evidence of safety and effectiveness because that information is already available to the FDA. Safety and effectiveness evidence accounts for the largest cost to a firm that seeks approval of an NDA.

"Paper" NDA: An NDA submitted to the FDA that relies on published reports of clinical studies showing safety and effectiveness. This application process in effect allows prospective marketers of duplicate drug products, originally approved *after* October 10, 1962, to bypass clinical studies. It is essentially a process that allows a prospective marketer of a duplicate drug product which was first approved *after* October 10, 1962, to take advantage of the ANDA process. However, if published studies on safety and effectiveness for this category of drugs do not exist (original developer may have chosen not to publish this information), prospective marketers of duplicate drug products cannot obtain NDA approval without incurring the costs of clinical trials.

The FDA's paper-NDA policy has been challenged by pharmaceutical manufacturers who fear they will receive less revenues from certain drug products as a consequence of increased competition. The FDA feels its action will promote increased competition and reduce societal expenditures for prescription drugs. However, the FDA also recognizes that society derives benefits from a policy that fosters research and development of previously unmarketed drugs, which in turn is dependent on adequate revenues that result from an exclusive marketing period for a producer of drugs.

Meanwhile, the FDA admits that when a prospective marketer of a duplicate drug product submits an ANDA or "paper" NDA, the FDA is not concerned whether that drug is still covered under patent. The FDA leaves it up to the patent holder to sue the marketer of a duplicate drug for patent infringement. This has encouraged small generic houses to duplicate drugs that are still covered under patent. They know that they can tie up these cases in court for several years while the incoming profits more than offset their court costs. Hopefully by the time the case is settled, the patent will have run out anyway.

It seems there is no easy answer. Conducting expensive duplicate clinical studies for the purpose of obtaining safety and effectiveness data already on file with the FDA consumes clinical resources unnecessarily and is clearly not in the interest of the drug-buying public. On the other hand, making it easier for marketers of duplicate products to copy original brands will cause manufacturers of original products to raise the selling price of new drugs so as to insure a satisfactory return on their investment. Either way the public loses.

Board of Pharmacy issues New Owner Guidelines

The Maryland Board of Pharmacy is providing these guidelines to assure your understanding of the responsibility you have as a *pharmacy owner* in our state.

1. The Pharmacy Department may not remain open when a pharmacist is not on duty. The remainder of the establishment may remain open if the Pharmacy Department is properly secured as required by Board of Pharmacy regulations.
2. The dispensing of prescription medication is the sole responsibility of the pharmacist and before it is dispensed, must be properly labeled, must be dispensed as a result of a bona fide prescription.
3. A non-pharmacist may not interfere with a pharmacist's professional judgement in the practice of pharmacy.
4. Maryland law requires that only the pharmacist or

pharmacy intern acting under the direct supervision of a pharmacist may advise a patient or customer about medications.

5. Board of Pharmacy and Division of Drug Control *inspection sheets* are enclosed for your review. Important sections of Maryland pharmacy law and regulations are covered. Be sure all stores and pharmacists are in compliance with these and all other regulations at all times.
6. Violation of either Maryland pharmacy law or Federal drug law could result in loss of your pharmacy permit. Be sure that all laws and regulations are understood and complied with at all times.
7. If and when you plan to permanently close your pharmacy, you must notify the Board of Pharmacy and Division of Drug Control to assure that drugs are properly disposed of and the transfer of the prescription files is orderly and in compliance with pharmacy regulations.

If you have any questions, please call 383-7245. If one of our staff cannot answer your question, a member of the Board will contact you within a reasonable time.



Pharmacy Students shown at recent School of Pharmacy Honors Convocation



The Officers for the Fourth Year Pharmacy class.

Pictures courtesy of District/Paramount Photo

—Quickie—

Well-known stage, radio and screen personality Will Rogers made this suggestion for getting rich: "Take all your savings and buy some good stock and hold it till it goes up and then sell it. If it don't go up, don't buy it."

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BITS AND PIECES

C. Philip Volk, a Pharm.D. student at the School of Pharmacy, has won an Oncology Fellowship from the American Society of Hospital Pharmacists Foundation. He will spend one year, beginning in July of 1982, at a cancer treatment center in an intensive program related to oncology pharmacy practice. Milton Moskowitz, outgoing American Society of Consultant Pharmacists President was recently presented with the first ASCP-Upjohn Award for his services to ASCP and Pharmacy. The Award of \$1,000 will be given to the School of Pharmacy in the recipient's name to be used for scholarship. H. Body Wylie, Jr., Melvin Rubin, and Philip Bogash each won \$750 in the Burroughs Wellcome Pharmacy Education Program. The money will be presented to the School of Pharmacy in their names to be used as a revolving loan fund for deserving pharmacy students. Congratulations to the following recently elected SAPH officers: Cheryl Betz, President; Taher Sheybani, Vice President; Carl Stinhilber, Secretary and Christina Choe, Treasurer.

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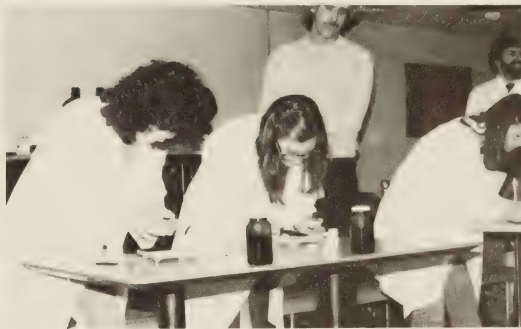
Dr. Robert Beardsley competed in the annual Rho Chi Pharmacy Olympics.



This annual event pits the students, faculty and various pharmacy organizations against one another in the finer arts of the pharmaceutical science.



Pharmacy students show they can pour, count, lick and stick.



All in good fun and for a good cause, this Rho Chi event helped it win the "Chapter of the Year" Award last year.

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

ORAL CONTRACEPTIVES:

A study involving approximately 2600 women has suggested that there is a continued increased risk of a myocardial infarction in women even after they have discontinued taking oral contraceptives. The risk of thromboembolism and myocardial infarction is well documented in women while taking these preparations, but now it seems that the risk remains for some time in spite of discontinuation of therapy. *N Engl J Med*, Vol. 305, #8, p. 420, 1981.

TETRACYCLINE:

The use of tetracycline during early stages of life can lead to abnormalities in the enamel of teeth. It has also been noted during surgical procedures and autopsies that people who have taken tetracycline for long periods of time develop a yellow color in their bones. This discoloration has been shown to be due to the deposition of the antibiotic, but thus far its presence seems innocuous. *J Am Med Assoc*, Vol. 246, #7, p. 761, 1981.

NSAID:

A wide variety of analgesics called non-steroidal anti-inflammatory drugs (NSAID) are available for use in the treatment of arthritis and other inflammatory conditions. They all seem to inhibit prostaglandin synthesis and although they do not appear to be clearly superior to aspirin therapeutically, they do produce fewer side-effects, especially gastrointestinal irritation. It is difficult to predict which NSAID will be most effective and least toxic in any given individual so clinicians have suggested that the less expensive agents be tried first with the more costly ones reserved for use when initial therapy fails to relieve the pain—or when they cause excessive gastric distress. There is no rationale for using more than one NSAID at a time. Drugs classified as NSAID include ibuprofen (Motrin), fenopfen (Nalfon) and naproxen (Naprosyn). *Drug Ther Bull*, Vol. 19, #14, p. 53, 1981.

ULCERATIVE COLITIS:

Sulfasalazine (Azulfidine) is utilized to treat ulcerative colitis. It exerts its effect by decomposing to form 5-aminosalicylic acid in the presence of colonic flora. A double-blind study used the active form of the drug in a retention enema and compared results obtained with those noted with enemas prepared using hydrocortisone. The 5-aminosalicylic acid enema produced almost twice the benefit as did hydrocortisone. *Lancet*, Vol. II, #8241, p. 270, 1981.

BENZODIAZEPINE METABOLISM:

When benzodiazepine derivatives are administered, there is a possibility that the activity can be either due to the parent compound or an active metabolite. When prazepam (Centrax) or clorazepate (Tranxene) are administered, little parent compound is found in the blood stream and the activity is produced by desmethyl diazepam, the major metabolite of both drugs. When diazepam (Valium) is administered, both diazepam and desmethyl diazepam are found in the plasma, but the concentration of the unbound metabolite is greater than that of the unbound parent drug—indicating that a major role is due to the metabolite. Other derivatives including oxazepam (Serax), lorazepam (Ativan), and temazepam (Restoril) are metabolized directly to inactive compounds and thus are likely to have shorter durations of action. Activity produced by the latter drugs is due only to the presence of the parent compound. *J Clin Pharmacol*, Vol. 21, #5, p. 219, 1981.

HEROIN:

More evidence has been accumulated indicating that the majority of the activity of heroin is due to its main metabolite, acetylmorphine, and not the parent compound itself. Heroin chemically is diacetylmorphine, but the acetyl groups are subject to removal by various enzyme systems. Studies comparing the activity of heroin, acetylmorphine, and morphine in other tissues suggest that the heroin molecule acts only as a lipid soluble moiety which facilitates access to the central nervous system. *J Pharmacol Exp Ther*, Vol. 218, #2, p. 409, 1981.

INSULIN:

Although insulin resistance is not extremely common, it usually involves excessive antibody buildup in the plasma which reacts with the insulin to inactivate it. It has been noted that intravenously administered insulin is effective in a patient while subcutaneously administered hormone is without action. Insulin can be degraded in the subcutaneous space in certain individuals. Enzymatic degradation is responsible for the loss of activity since aprotinin, a protease inhibitor, can be used with the insulin subcutaneously and the effectiveness of the injections is restored. *N Engl J Med*, Vol. 305, #7, p. 363, 1981.

RESPIRATORY FUNCTION:

Some patients with chronic bronchitis and emphysema may maintain a low or normal carbon dioxide concentration in their plasma and a nearly normal oxy-

gen tension by breathing very rapidly. These patients are referred to as "pink puffers" and have very little capacity for exercise. Initial studies indicate that certain sedatives may help alleviate tension and improve respiratory function in these people. Promethazine (Phenergan) and diazepam (Valium) were used in a double-blind, crossover study to see if one drug might be superior to the other in treating such patients. It appears that promethazine is useful in increasing exercise tolerance, while diazepam did not help. It is suggested that benzodiazepine derivatives be avoided in patients with this respiratory problem. *Br Med J*, Vol. 283, #6287, p. 343, 1981.

GOLD TOXICITY:

Patients with rheumatoid arthritis may require administration of gold salts in order to help control their inflammatory condition. Gold toxicity includes symptoms such as stomatitis, dermatitis, proteinuria, and thrombocytopenia. The thrombocytopenia is seen in approximately 2% of the patients receiving gold therapy. It is thought to be mediated through immunological mechanisms as genes of the major histocompatibility complex seem to be involved. *Ann Int Med*, Vol. 95, #2, p. 178, 1981.

METHYL MERCURY POISONING:

Methyl mercury is an organic form of the metal with capacity to produce severe toxicity in humans. An outbreak of toxicity occurred in Iraq after the compound was used as a fungicide for wheat and the flour was still contaminated when it was used to make bread. Several antidotes were used successfully to reduce blood levels and to accelerate excretion, but it was noted that the agents were most effective if used before irreversible damage had occurred. Three complexing agents and a thiolated resin were among the antidotes used. *J Pharmacol Exp Ther*, Vol. 218, #1, p. 74, 1981.

METHACHOLINE:

Some patients experience respiratory difficulties without showing all of the signs of asthma. Hyperreactive bronchiolar tissue is responsible for these symptoms, so a simple test has been devised to demonstrate the presence of this condition. The patient is asked to inhale an aerosolized preparation containing methacholine. Sensitive patients react more dramatically than do controls and thus a diagnosis of asthma should be considered. *J Am Med Assoc*, Vol. 246, #3, p. 225, 1981.

FLUARIZINE:

A new calcium antagonist, flunarizine, was used in a group of female patients with urinary frequency and incontinence. Side-effects were minimal and the study showed the drug to be useful for these complaints. *Lancet*, Vol. II, #8241, p. 279, 1981.

OSTEOPOROSIS

Elderly patients experience osteoporosis to a greater degree than do younger people. Research conducted in both young and older groups of volunteers has indicated that the more youthful group has a reserve of the active form of vitamin D (1, 25, dihydroxy vitamin D). This will be useful in maintaining adequate calcium levels during times when levels might otherwise drop. This reserve is absent in elderly patients with osteoporosis and thus calcium is taken from bone in order to maintain adequate levels. This offers an explanation as to why this condition is seen more frequently in the elderly. *N Engl J Med*, Vol. 305, #7, p. 372, 1981.

SLOW CALCIUM CHANNEL BLOCKERS:

Nifedipine and verapamil are two agents in a new pharmacological class of drugs called slow calcium channel blocking agents. These drugs are being used to help prevent contraction of arteriolar smooth muscle and may be effective in treating patients with variant angina. It has been suggested that these drugs might be useful in treating asthmatic conditions since these situations are also brought on by excessive contraction of smooth musculature. The contraction of smooth muscle is dependent on the influx of calcium from outside of the cell and since these drugs block this inward ionic movement, they may be of value in reducing or eliminating symptoms of asthma. *Ann Intern Med*, Vol. 95, #2, p. 232, 1981.

HYDROCARBON INGESTION:

In order to help determine when a child who ingests liquids containing hydrocarbons should be hospitalized, clinical records of 950 such children were reviewed. It was noted that most children do not develop symptoms of pneumonia and the authors have suggested that only those who are symptomatic upon presentation or who develop symptoms during the 6 to 8 hours observation period should be hospitalized. Approximately 5% of the accidental poisonings in children under the age of 5 years are caused by hydrocarbon-containing products such as furniture polish, gasoline, paint thinners, etc. *J Am Med Assoc*, Vol. 246, #8, p. 840, 1981.

ENDOTOXIN SHOCK:

Bacterial endotoxin shock is associated with a variety of changes which occur in the physiological functions of the body including an increase in the synthesis of thromboxane, a substance which enhances platelet aggregation and clot formation. Aspirin has been found useful in helping prevent some of the complications of endotoxin shock and it is suggested that the protective action of the salicylates is due to their ability to inhibit the synthesis of thromboxane. This would reduce platelet aggregation and clot formation. *J Pharmacol Exp Ther*, Vol. 218, #2, p. 464, 1981.

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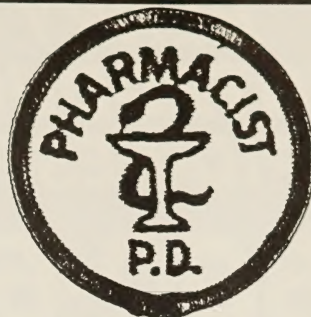
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The University of Maryland School of Pharmacy is interested in including 4 antique pharmacy fixtures in its new building, planned for completion in 1983. Anyone interested in such an idea is invited to call the Dean's Office, 528-7650.

calendar



- Dec. 3 (Thursday)—MPhA Board Meeting, Kelly Building
- Dec. 8 (Tuesday)—AZO Dinner Meeting-Chiparellis, Towson.
- Jan. 11-18—MPhA Trip to Cancun
- Feb. 14 (Sunday)—BMFA Dinner-Dance.
- April 24-29—APHA Convention, Las Vegas
- Mar. 14 (Sunday)—Alumi Association Dinner Meeting
- Jun. 20-24—MPhA Centennial Convention Ocean City.

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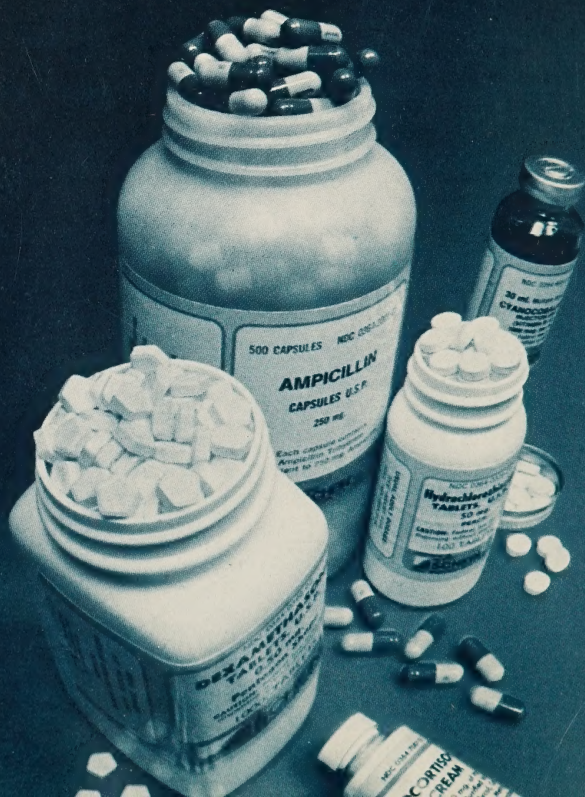
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